

## California State Journal of Medicine.

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Medical Society of the State of California

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### EDITORIAL NOTES.

The San Jose meeting of the State Society, now a thing of the past, was a distinct success. The full minutes of the proceedings of the **SAN JOSE** House of Delegates will be found in **MEETING.** this issue, together with the reports of officers. It will be seen from these that the Society was never in better condition than at the present time. In spite of many setbacks, we have steadily increased in numbers and we have also steadily reduced our obligations. There were 316 registered in attendance and doubtless, as is always the case, a number more who forgot to register. The tone of the program was excellent and some of the sessions worthy of the highest commendation. The President, Dr. Beckett, enforced the rule limiting authors and speakers to ten and five minutes respectively, and once more it was demonstrated to be a very wise rule. The newly elected President, Dr. Jas. H. Parkinson, of Sacramento, is known to most of our members and will undoubtedly guide the Society with a sure and a wise head during the coming year. The next meeting will be held at Sacramento, the third week in April, 1910. It is unfortunate that, probably through oversight in the confusion of electing a large number of committeemen, the Chairman of the Public Health Committee, Dr. F. C. E. Mattison, who has done such masterly work in organizing and making so very important this committee, was not reelected. No words of commendation can too highly praise the work that Dr. Mattison has done for the Society and for the Public Health of the people during the last two years, during which he has given liberally of his

time and his energy for the furthering of the work of this committee. It is a sorrow to see him discontinue it and we can only hope that the new committee may continue the work as energetically and as satisfactorily as the former committee did under the management of Dr. Mattison.

In the last legislature were introduced a number of bills affecting the status of those who desire to treat the sick. The Naturopaths

**WHY THESE ASSAULTS?** wanted a law creating a board of examiners in Naturopathy; the chiropractics wanted a similar board for their peculiar cult, whatever it may be; there were two bills creating entirely new and original laws to regulate the practice of medicine and of osteopathy and two more which, at the beginning of things, merely amended the present law and created reciprocity. One of these, A. B. 1331, by Silver, was later amended to include all the bad features of all the others, and some in addition! The question is often asked, "Why are there so many attacks upon the medical law?" One reason is this: Any person may engage a lawyer as his professional adviser; there are many lawyers in the legislature; if the client of such an one desires a bill introduced, his lawyer-legislator naturally takes a great interest in that bill. This is not called "graft" by the legal profession; it is merely the system by means of which the great industries have had, for many years, very friendly congresses to make laws for them. It is therefore clear how such bills may be introduced and why the introducers may fight hard for their passage. But the number of such attorneys is small. Another reason, a vastly more important one, is the prevailing ignorance of the whole subject. Some people come along and want a board of examiners in "comforthealing"; they state at once that they do *not* wish to practice medicine; not at all; *only* comforthealing, which is mysteriously different from anything else and makes sick people well without doing anything to them. That sort of argument impresses a good many intelligent legislators who say "Why do you oppose these men? They do not ask to practice *medicine* and their bill is so drawn that they can *not* practice anything but 'comforthealing'; can not prescribe or operate or call themselves doctors." All of this is beautifully fine and simple—on the surface of it. But the legislator does not know the facts; he does not know that every one of these applicants to do these certain and sundry peculiar things is really and actually going to practice medicine as soon as he gets his license to practice something else.

A graphic illustration of this was furnished within ten days after the last meeting of the Board of Medical Examiners. The legislature

**CASE IN POINT.** amended the present law and compelled the board to endorse certificates from the "Board of Naturopathic Examiners" which had been issued prior to the passage of the amendment. Some fifty were so indorsed on April 7th. Within a few days an agent for one of

the new and exclusive buildings in San Francisco telephoned to the office of the board to know if "John Doe" was licensed to practice and was all right. He was informed that no one of that name was licensed to practice medicine in this State. Now comes "John Doe," most indignant, says that his certificate was endorsed by the Board April 7th, that he is an M. D., and that he intends to practice medicine. He was authorized by the legislature to practice Naturopathy, *and that only*; not to practice medicine, to operate or to prescribe drugs; yet he openly states that he intends to practice medicine. What are you going to do about it? Invoke the law? Fine! But from whence is coming the money to hunt out and prosecute the many hundreds of such cases that exist now, and the many thousands that would exist with all these wide open doorways to the easy practice of medicine? If a crusade against them was begun, assuming that ample funds were at hand, how tremendous would be the work! Here is the case of a man who graduated from some medical school, tried to pass the examination and obtain a license to practice medicine, and failed. He joins the naturopaths, possibly after a few weeks' reading, and is subsequently licensed, by the manner described, to practice that cult. He comes into court, shows that he has a degree of M. D. (the court knows not one school from another) and says that he is being "persecuted" because he is a better man than the regular society physicians. He is promptly acquitted. This the history, not of one case only, but of very many. Large numbers of people would like to treat the sick in some esoteric manner—*because the sick are easy prey*; if they can obtain legal recognition of any form whatsoever, they will very shortly thereafter be practicing medicine. But the average layman—and this includes the representatives from your own district, in all probability, does not understand this at all; he never sees the crooked work underneath because the faddist speaks him fair and his words sound plausible.

Another reason for the attacks upon medical standards—and "medical standards" might be

written *safeguards against ignorance and quackery*—is one that brings to **ANOTHER REASON.** our own threshold a certain amount of shame: The complete lack of confidence in our profession caused by the eternal differences and squabbles among medical men themselves. From a private letter written by a high-minded lawyer who sat in the last Senate and voted for Assembly bill 1331, the following may be quoted as driving this home in no uncertain way.

"Now among lawyers, the rule is entirely different and no such jealousy or illwill exists among them as appears to exist among the members of the medical profession in the State of California. \* \* \* it certainly is very annoying and perplexing to the average legislator and he is at a loss to know the right thing to do as the doctors are divided themselves."

There it is, the same old story! The "doctors are divided among themselves"; they do not know what they want; some want one thing and others clamor equally loudly for something else. And how is the layman to tell the sheep from the goats; they are all equally physicians and equally eminent in their profession, so far as he can judge. The layman does not know the undercurrents, and there is mighty little time in which to point them out to a legislator when the legislature is in session. There is always some one good point put into these vicious bills about which their advocates can talk and thus gain support, ignoring the "joker" which they always contain. Or, this apparently good point may be a very bad one if its ultimate operation is studied out. Thus, Dr. Geo. L. Eaton argued at Sacramento that A. B. 1331 should pass because, as things are now, if the most eminent surgeon in New York or Chicago should come to California he could not perform an operation unless he had submitted himself to an examination at the hands of a board composed of men admittedly less competent than himself. He did not go on to explain why the bill was so urgently desired by the College of P. & S. of San Francisco (so recently for sale) and the Los Angeles College of Osteopathy, one of whose professors admitted that its graduates could not pass our board examinations. Why? The single plea that a really big man can not come here and practice without taking the examination, excites enough sympathy for the oppressed to obliterate all thought of the reasonable objections. This sympathy for the really great man, if carried out, would lead to the influx of 80 per cent. of those rejected by our examinations and thousands of at least equally ignorant osteopaths. But the schools that dislike high standards do not care about such trifles as this; and the legislator does not know the real conditions. A Senator, also a lawyer and a gentleman, puts your plain duty and your chief work for the next year or so very plainly before you in this statement:

"It is hard indeed for a member of the legislature to know the right thing to do concerning the various medical bills that come before the legislature. On one hand we have \* \* and other equally eminent medical gentlemen contending that one bill is vicious and should not be passed and on the other hand we have such men as Winslow Anderson, Geo. L. Eaton, T. C. McSwain and other regular practitioners, who contend that the bill should be passed; so between the two, it is pretty hard for the layman to determine what is the right thing to do."

The vote on this bill, Assembly 1331, which so nearly became a law, is certainly peculiar and worthy of careful study. In the Assembly, after **BILL** its various amendments, it came to final vote on March 13th. Fifty Assemblymen voted for its passage and not a single vote was recorded against it. Here is the roll call as taken from the official Daily Journal of the Assembly:

Ayes—Messrs. Barndollar, Beatty, Beban, Black, Bohnett, Callan, Cattell, Coghlan, Collum, Cronin, Dean, Drew, Feeley, Flint, Gerdes, Gillis, Greer, Griffiths, Hammon, Hanlon, Hawk, Hewitt, Hinkle, Holmquist, Irwin, Johnson of Sacramento, Johnson of San Diego, Juilliard, Kehoe, Leeds, Lightner, Maher, McManus, Melrose, Mendenhall, Moore, Nelson, Otis, Preston, Sackett, Schmitt, Silver, Stuckenbruck, Telfer, Transue, Wagner, Wheelan, Whitney, Wyllie, and Young—50.

Noes—None.

In the Senate, things were not so simple. It came up for final passage on March 20th. Senator Willis asked to be excused from voting, and the following Senators *voted for the passage of this bill which would have been such a blow to the protection of the people*: Anthony, San Francisco; Campbell, San Luis Obispo; Cartwright, Fresno; Curtin, Sonora; Cutten, Eureka; Estudillo, Riverside (in order to have the right to move for reconsideration); Finn, San Francisco; Hare, San Francisco; Hartman, San Francisco; Hurd, Los Angeles; Kennedy, San Francisco; Leavitt, Oakland; Martinelli, San Rafael; Miller, Visalia; Reily, San Francisco; Rush, Suisun; Sanford, Ukiah; Savage, San Pedro; Strobbridge, Hayward; Walker, San Jose; Welch, San Francisco; Wright, San Diego.

Estudillo voted against the bill but finding it had passed changed his vote from "no" to "aye" and gave notice that he would move to reconsider. On Monday, March 22d, Estudillo moved that the action be reconsidered. This motion was put and carried. The vote was again taken on the final passage of the bill and of those named above *Caminetti, Curtin, Leavitt, Rush, Walker and Willis* changed their votes and voted *against* the bill. Wright was absent and did not vote. Birdsall and Boynton, not recorded as voting for the previous passage of the bill, are recorded as voting *against* it when it came to reconsideration. Of the Senators named, the term of office of the following has expired; some of them will want to be re-elected:

Anthony, Caminetti, Cartwright, Curtin, Hartman, Kennedy, Leavitt, Miller, Reily, Sanford, Savage and Wright.

On March 31st a most remarkable thing occurred; the citizens of San Francisco tendered a banquet to a physician and presented him with a magnificent watch. A **NOTABLE BANQUET.** year and a half ago the same citizens were ready to mob any one who suggested that there was any necessity for calling upon Dr. Blue or any one else to fight plague, for the reason that, in their almighty opinion, no plague existed in San Francisco. But all things change; and so did the opinion of these distinguished citizens—including the mayor. The Council of the State Society called a public meeting and through some happy accident, two members of the Merchants' Exchange, out of some eight hundred members of the commercial bodies that had been invited, attended the meeting. These two listened to the remarks made by the physicians present and came

to the conclusion that they had better wake up before the city was quarantined. The rest is history. The fight was a hard one for Dr. Rupert Blue, because he had to fight not only the plague but an ignorant and an antagonistic people; but he won. His tact, his courtesy and his efficiency are known to all who have come in contact with him and the prominent citizens of San Francisco certainly did themselves great honor when they so publicly admitted their previous stubbornness and their very present gratitude and apology.

Sometimes one is lead to believe that the 20th is a retrogressive century. Certainly there must be a very large number of exceedingly ignorant people in the world—**ABOUT ANTI-VACCINATION.** and especially in California—if we are to take the attitude of the last legislature as in any way indicating the average intelligence. Mr. Harry Barndollar, of the Sixty-ninth District, Long Beach, introduced a bill (A. B. 992) which practically does away with compulsory vaccination; and it passed both Assembly and Senate. At the time of writing it is in the hands of the Governor who, it is to be hoped, will veto it. Why not take this up with our representatives and ask them to explain *why* they wished to put our State back many years and endanger the lives of many thousands of our citizens by doing away with our one protection against epidemic smallpox? Why should not the Long Beach branch of the Los Angeles County Association have Mr. Barndollar attend one of its meetings and discuss vaccination, incidentally asking him to *explain his attitude* on this most important public health measure? Furthermore, the physicians in the Sixty-ninth Assembly District should talk the matter over with the leading citizens who are active politically and call their attention to the mistaken activity of Mr. Barndollar so that, if he is again elected to represent that district, he will be better posted on the subject of vaccination and better able to avoid doing the State great injury. It is purely a matter of education. A few cranks (alas! some of them physicians), speaking in a loud and would-be authoritative voice, make statements against vaccination that stick in the untutored mind; it takes time and argument to get these ideas out. Here are the names of the Assemblymen who *voted in favor of doing away with compulsory vaccination*:

Barndollar, Long Beach; Beardslee, Stockton; Beatty, San Francisco; Black, San Francisco; Bohnett, San Jose; Butler, San Rafael; Callan, San Francisco; Cattell, Pasadena; Cogswell, El Monte; Costar, Chico; Cronin, Benicia; Cullen, San Francisco; Dean, Redding; Flavell, Ontario; Fleisher, Santa Maria; Flint, Hollister; Gillis, Yreka; Griffiths, Monticello; Hanlon, Los Angeles; Hewitt, Yuba City; Hinkle, San Diego; Holmquist, Redwood City; Irwin, Bakersfield; Johnson, San Diego; Johnston, Richmond; Kehoe, Eureka; Leeds, Los Angeles; Maher, Santa Cruz; McClellan, Bridgeville; Mendenhall, Williams; Moore, Copperopolis; Mott, Oakland; Odom, Coalinga; Otis, Alameda;



Perine, San Francisco; Preston, Ukiah; Pulcifer, Oakland; Rech, Los Angeles; Rutherford, Truckee; Sackett, Ventura; Silver, Pleasanton; Stuckenbruck, Acampo; Telfer, San Jose; Wagner, Madera; Webber, Hanford; Whitney, Healdsburg; Wilson, Winters; and Young, Berkeley.

*Here are the Senators who voted to do away with compulsory vaccination:* Bates, Alameda; Bell, Pasadena; Bills, Sacramento; Birdsall, Auburn; Caminetti, Jackson; Campbell, San Luis Obispo; Curtin, Sonora; Finn, San Francisco; Hare, San Francisco; Hurd, Los Angeles; Leavitt, Oakland; Lewis, Stockton; Martinelli, San Rafael; Miller, Visalia; Rush, Suisun; Sanford, Ukiah; Savage, San Pedro; Strobbridge, Hayward; Thompson, Alhambra; Walker, San Jose; Weed, Dunsmuir; Willis, Redlands; Wright, San Diego.

#### REPORT OF PRESIDENT TO THE HOUSE OF DELEGATES.

W. W. BECKETT, M. D.

During the past year there has been a gain in membership of about one hundred. This is small when we consider the number of new doctors that are continually coming into our State, and the new doctors that are being graduated annually from our local schools, and that we have about 2000 non-members. There should be a greater effort made by the County Societies to get in new members. The sending of the programs of the Society meetings, with an invitation to attend, and also a membership blank to be filled out, to non-members, might do much toward increasing the membership of the local societies.

The education of the laity along health and sanitary lines should be pushed more vigorously in the future than has been done in the past. The work done by the State Board of Health in preparing the Sanitation Car Exhibit will be an object lesson that will do more to educate the public along these lines than probably any other method that could be devised. The car should be advertised extensively by the local societies in advance of its coming to their localities.

Public addresses, newspaper and magazine articles by members of our society, would do much toward bringing about a greater sentiment in favor of compulsory vaccination, regulating pure drug and pure food laws, the care of the tuberculous poor, the quarantine of infectious diseases, a high standard of medical education, and the elimination of quacks and the nostrum evil; and should also very materially help in checking the progress of the Great White Plague and in staying the ravages made by the Greater Black Plague.

The recommendation made by my predecessor that the County Societies take up the post-graduate course that has been prepared by the American Medical Association has been but poorly carried out, or not at all. Invaluable good could be done by a thorough organization of the County Societies into post-graduate schools, and it is to be hoped that many of our component societies will take up this work during the coming year.

That our medical laws may not be interfered with, it is very important that we nominate only the best men we have in our society for positions on the State Board of Medical Examiners. If we can place five staunch men and true on the Board for the coming two years, much, if not all, of the criticisms that have been made against the present law, will be overcome, and we will occupy a very different position in the eyes of the public. I therefore recommend that you select with great care, only those who will fill these positions with credit to themselves and to this society.

At the last meeting of the American Medical Association quite a large number of our members were in attendance, yet only a part of our delegates were present. This should not be. Only members who will attend these meetings should be elected delegates. At most of these meetings we are usually without a full representation.

The persistent fight our Secretary has made, through our State Journal, against the Nostrum evil, and the good work done by him at Sacramento in upholding and maintaining our present State Medical law, should be commended by every member of our society.

Reciprocity has now been adopted by about twenty-seven States. The council of education of the A. M. A. is doing much to elevate the standard of medical education and in time it is to be hoped that a uniform standard may be attained by all the medical schools throughout the country. There should be reciprocity between States having the same legal requirements and when there is a uniform standard for all practitioners throughout the United States, then there should be reciprocity between all the States. The fight that was waged against our State medical law during the recent session of the State Legislature by the Naturopaths and others, was probably the most persistent and best organized of any that has ever taken place in this State. An anti-vaccination law was passed by both houses, but fortunately, was vetoed by the Governor. Bills of all sorts, intend to change the present medical law in all sorts of ways, were introduced and one was passed, but owing to the heroic work, of some of our members, was reconsidered and defeated.

If we are to preserve a medical law that will protect the public against quackery and ignorance, and maintain the present standard of medical education, it will be essential that we organize early, in every county in the State, so that we may ascertain before the primaries meet, who we can depend upon to vote for bills recommended by our Legislative Committee.

Governor Gillett should be especially commended by this Society for the earnest effort he has made in favor of just medical legislation. Those members of the Legislature who stood by us and voted to maintain our present medical law, should have our gratitude and our united support.

It should be the object of this association to promote concord and fraternity, unity and strength, the advancement of our knowledge, the protection of our own interests, and to uphold the honor of our



profession. The possibilities of this association are great, its influence which is increasing year after year, will last as a living power for good and remain a valuable legacy for the benefit of posterity. Our profession is heaven-born, and we may have the satisfaction of knowing that we are doing a noble Christian work in our effort to cure disease and alleviate human suffering. May harmony and good fellowship prevail throughout the sessions of this meeting.

#### REPORT OF THE SECRETARY.

*To the President and Members of the House of Delegates:*

Gentlemen:

As it is the province of the Council to report to your honorable body the financial condition of the Society and all matters relating to its publications, I will not discuss that portion of the year's work except to say that I was surprised to see any financial gain whatever during the year last passed.

In 1902, with a membership in the State Society of some 300 and with scarcely more than \$700.00 in the treasury, we undertook the reorganization of the Society and the publication of a Journal. There was no office and no office equipment. There was little if any general society work to be done for the Society really existed only on paper; save once a year, at the annual meeting. But the office of the State Society is not unlike a central exchange in a telephone system; with the development of individual activity—with the growth of organization and of interest—has come an enormous increase in the amount of work thrown upon the exchange. From month to month and from year to year this work has grown and consequently our expenses have greatly increased. In spite of this fact, and in spite of the further fact that we were completely wiped out in 1906, and, like every one else, were subjected to the financial panic of 1907-08, we have been able steadily to reduce our indebtedness each year, to re-equip completely our office, to extend greatly the work of organization and to be of greater use to our members throughout the State, as evidenced by the much enlarged volume of correspondence.

It is evident to me, however, that we shall not be able to reduce our note of \$2,000.000 more rapidly than to an extent of a few hundreds of dollars a year, without seriously crippling the general work of the Society and absolutely stopping all further organization work. As this would be calamitous, I respectfully suggest that the Council be authorized to take up the note for \$2,000.00 now outstanding and issue in its stead 20 notes of \$100 each, to be taken up by members, and that these notes be paid in units of \$100, from year to year as funds are available. This year, for example, we shall be able to take up from one to five of such units, if nothing unforeseen prevents.

During the year, the Society has increased in membership, and shows a decidedly healthier condition than a year ago. Forty-one members have died and thirteen have resigned or been dropped.

On April 15th, the total membership was 1858, a net increase of 117 over last year, and the largest yet reached. Fourteen county societies have gained 124 members; one has been re-enlivened and has 21 members; three, Kings, Stanislaus and Tehama have not reported and the remaining ten show a loss of 22 members, though in several cases the final reports from these societies are not yet in.

The societies which have gained in membership are as follows: Alameda 9, Butte 3, Los Angeles 13, Monterey 2, Riverside 6, San Diego 20, San Francisco 51, San Joaquin 3, San Luis Obispo 2, San Mateo 8, Santa Clara 3, Shasta 2, Sonoma 4, Yuba-Sutter 1.

It is most interesting to see that interest in county society work is steadily increasing and that some sections which never before had shown any particular interest in organization work, are now waking up and taking a good deal of interest in it. But we are just beginning. If we are to prevent the repetition of the fierce onslaughts upon our medical law and upon public health laws in general, we must do a great deal of organization work this next two years and each county society must take care of its own Assembly districts and see that its prominent citizens are educated to a proper understanding of the protective significance of these public health laws—of which laws that regulating the practice of medicine is by no means the least important. I have compiled a list of the members of the last legislature and the way in which each one voted on all public health laws. With your permission, I shall send to the medical society in each district the record of the legislators from that district; is it not then the duty of the local medical society, and of each of its members individually, to have an explanation from those of our legislators who voted against the public health of the people?

The Journal during 1908 printed 430 pages of reading matter including 122 original articles and 82 reports of societies, etc., of some length. No other medical journal on the Pacific Coast has presented to its readers anything like this amount of material. The quality of matter could be distinctly improved if you would give more of your best work to your own Journal; but even as things are, the extent to which articles appearing in your Journal are referred to and abstracted shows that it must contain at least some articles of more than trifling merit. To that extent to which you will co-operate, will your Journal be improved and bettered. The editor can do only a little; the members of the Society can do a great deal to improve the Journal.

If the work of the Society is to be continued and not curtailed, the assessment for 1910 should be fixed at \$3.00; a smaller amount will necessitate cutting off a great deal of work that should be done.

It is to be hoped that some practicable plan for undertaking the defense of our members in malpractice suits may soon be adopted and placed in operation. Other states have tried this with marked success and it has added materially to the ad-

vantages of membership. The Society exists only for the benefit and improvement of its members and this undertaking will certainly be a great benefit and a not inconsiderable saving to them.

Respectfully submitted,  
PHILIP MILLS JONES, Secretary.

### REPORT OF THE COUNCIL.

*To the House of Delegates, Medical Society, State of California:*

The current year has been uneventful as regard to stirring events. The Council have held several meetings, transacting the business properly coming before it.

As will appear by the several reports submitted, the Society is in a good state of efficiency, the membership being slightly increased, while the interest manifested by the component Societies is up to standard.

The card files have been brought into good and complete order.

The business of the JOURNAL is better than before, with every prospect of further improvement.

The following is the report of the Council:

The year of 1908 saw a financial depression over the whole country which did not fail to affect our Society. Through failures, etc., the JOURNAL lost \$278.00, the largest sum that has yet been charged to profit and loss since we began publication in 1902.

Advertisements were withdrawn to the extent of \$900.00, thus making a total loss on JOURNAL business, from what was expected in the beginning of the year, of \$1,178.00.

However, for the first time we are able to present a statement of the year's business uncomplicated with inheritances from previous years, except \$890.00 paid for JOURNAL account incurred in 1907.

The statement presented to you, which is the auditor's report to the Council after expending the Secretary's books, includes only the receipts and expenses for 1908; no bills remained unpaid.

The total receipts for the year were \$1,505.29 less than for the year 1907, and the total disbursements were \$1,075.58 less than the preceding year. It will therefore be apparent that we were injuriously affected during the year to the extent of nearly \$1,608.71. In spite of the fact, our JOURNAL has shown a slight increase in net earnings and our actual liabilities have been reduced somewhat as we see from the following figures:

Considering our actual liabilities only, and making no deduction therefrom for stock on hand, fixtures, petty cash, etc., we find actual liabilities—

January 1, 1907.....	\$3,909.44
January 1, 1908.....	2,912.28
January 1, 1909.....	2,447.12

thus in three years, and in spite of losses from fire and from the business depression of last year, we have reduced our liabilities to the extent of \$1,462.32. It must also be remembered that our expenses have increased in almost every direction.

Salaries, 1908 .....	\$5,077.00
" 1906 .....	3,883.00

Increase .....	\$1,194.00
Organization, 1908 .....	\$309.75
" 1906 .....	99.70

Increase .....	\$210.05
Society expense, 1908.....	\$582.65
" " 1906 .....	304.61

Increase .....	\$278.04
Office expenses, 1908.....	\$807.91
" " 1907 .....	547.68

Increase .....	\$260.23
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Total increase in disbursements in these four items is therefore \$1,942.32.

On the other hand, all back indebtedness on JOURNAL account has now been paid and the JOURNAL shows a slightly increased net earning capacity. In 1906 the books showed \$288.00 excess of receipts over expenditures; in 1907, this was \$594.00; in 1908 it was \$958.00. It may be said, parenthetically, that business conditions are decidedly improving with the early months of the present year; already two pages of new advertisements have been received and others are anticipated.

In August it became apparent that it would be quite impossible to make any payment upon our note for \$2,000.00, and a meeting of the Council was called to consider our financial status. At this meeting the Secretary was instructed to present a report, at some future date, with suggestions as to how we might reduce our expenses. He subsequently reported to me that he could see no way in which our expenses could be reduced save by reducing his salary and he, therefore, with my consent and without waiting for a meeting of the Council, reduced his salary for 1909 to the extent of \$500.00.

With this reduction, with no inheritance of unpaid bills from the preceding year, and with the improvement in business conditions in view, we believe that it will be possible to reduce our loan to the extent of a few hundred dollars during the present year.

The actual cost of printing and distributing the twelve issues of the JOURNAL for 1908—all JOURNAL expenses—was \$2,839.23. This is less than the amount which appears on the statement in your hands because \$891.27 was paid in January, 1908, for JOURNAL expenses of a previous year, and \$60.00 was paid in January, 1909, for the paper used in the December (1908) issue.

The Register for the past three years has been published by Mr. Henry Kaplan without expense to the Society. The information is compiled in our office and in return for this, a copy of the book is sent to each member. A plan is under consideration by means of which the Register may be issued quarterly and thus more accurate information furnished; many hundreds of changes occur each year.

C. G. KENYON, Chairman.

## REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

F. B. CARPENTER, M. D., Chairman.

Among the many bills introduced in the Legislature at the session just closed, those affecting medical matters were quite numerous; as for that matter they are at every session, and seem to be annually on the increase. Of them all, however, but two received serious consideration at the hands of the Sacramento Solons. One of these was a bill drawn in the interest of the Naturopaths, establishing a Board of Naturopaths, to be appointed by the Governor, and legalizing those already practicing Naturopathy in the State. This bill had a large following in both houses, was championed by strong leaders and stood a good prospect of passing as it was framed. In lieu of this an amendment to the present medical law was finally drafted which admitted to practice (legilized) those Naturopaths who were already in practice and required all Naturopaths who might hereafter apply for license to practice, to take the examinations of the State Board.

This bill as amended was finally passed, signed by the Governor, and is now a part of the State Medical Law. After the passage of this bill another bill, putting the appointment of the Board of Examiners in the hands of the Governor, and establishing reciprocity with other States, passed both houses, and needed only the Governor's signature to make it a law, when it would have replaced the present amended statute and we would have enjoyed the luxury of a political Board, and the privilege of exchanging compliments with other States, the standards of which are as questionable as would be the policy of the average political Board.

After this bill had passed both houses, Dr. Parkinson, who at the time was keeping in close touch with the Legislature and their doings, succeeded in securing its reconsideration by the Senate, when it was fortunately defeated by a small majority. It has always been the policy of your Legislative Committee, and we believe it to be the correct policy, to oppose any legislation which will place the appointment of the Board of Examiners in the hands of the Governor. Such an appointing power is undesirable, not that the Governor would not do his duty according to his best advice, but that he must depend for that advice upon consultation with a few of his personal friends or acquaintances, rather than upon the collective judgment of the assembled profession. It has, also, been our policy to oppose reciprocity with other States, for the reason that many States recognize the certificates issued by other States; and to recognize one, recognizes all with which that one may reciprocate; and as there are many lax and political Boards throughout the country, such a course would expose California to an influx of licentiates with all sorts of credentials. The high standing of the California State Board has gone abroad through the land, and since we have set the mark high, let us maintain it.

I recall that some years ago the address of the President of this Society dealt very liberally with

the question of "the Doctor in Politics." It was forcibly argued that the doctor should take an interest in public questions, and it was shown wherein he might be of service to the general public.

Now, here is further argument why he should under certain conditions, become a public man, so-called. The medical man, as a member of the State Legislature, is well qualified to pass upon many questions coming before that body. Much matter of importance is referred to him by his colleagues, and his judgment and opinion respected by those with whom he associates. Experience in matters political has shown the advisability of there being more medical men in the State Legislature. The medical man in either house can do more to correct the ways of the average politician than can a whole County Medical Society from afar. I know of no one better fitted to adorn politics than the doctor, and to him we look to make political position an honor, and to reflect credit upon his party and his profession.

Now, adopt the practical side of this question, and make it your business within the coming year and years, to see that when there is a legislative opening in your district, that it is filled by a doctor. It will be to his credit, to your advantage and to the advantage of all the people.

## REPORT OF THE PUBLIC HEALTH COMMISSION OF THE MEDICAL SOCIETY OF THE STATE OF CALIFORNIA FOR THE YEAR 1908-1909.

F. C. E. MATTISON, M. D., Chairman.

Mr. President and Members of the Society:

The work of the Public Health Commission during the last year has been largely educational, the major efforts being directed to inducing the country public health committees to take up the work in more aggressive fashion.

As the commission has striven to solve the many problems still before us, it began to realize the needs of a closer and more comprehensive organization; an organization that would weld together in a federated union all the public health agencies of California, viz.—the California State Board of Health, the California Public Health Officers Association, the Public Health Commission of the Society, the District Public Health Officers Association, and the County Medical Association Public Health Committees, and in an advisory capacity all other organizations and individuals working for these same ends.

A call has therefore been issued for such a meeting to be held at San Jose during this meeting, and it is hoped that that conference will enable such a union to be brought about.

There is a great need for concentrating all public health activities in a central body and of giving to our State Board of Health, the power that is now distributed among some lay boards, like the Dairy Commission.

As a majority of the members of the Executive Committee of this Public Health Commission live in Southern California, they have sought personally



to become further acquainted with the public health needs of the communities of that section.

The production of clean milk by all dairies, the need of enforcing the tuberculin test on all dairy cattle in California, the inauguration and maintenance of certified dairies, the need of securing better laws for the supervision of the dairy industry of California, have taken much time and effort in their study. The enforcement of the pure food laws, the disposal of garbage and sewage, the adequate inspection of bake-shops and other establishments producing food stuffs have been other subjects of discussion and investigation.

The efforts put forth to secure for Los Angeles a scientific disposal of sewage, which would be a model for other cities in the State necessitated many meetings with committees from various civic bodies and will no doubt result in better regulation of the very important measure.

This lack of organization among the profession prevented any strong effort being made during the recent State Legislature, to bring about the passage of laws on dairy inspection. This lack of organization was made even more manifest when our State medical law was in jeopardy. In this connection we may state that we secured from Dr. George H. Simmons, editor of the *Journal of the A. M. A.*, several hundred copies of the last report of the Association of American Medical Colleges, and distributed a copy of this report with other literature in support of high medical standards to members of the Senate and Assembly.

During the past year the members of the Public Health Commission have given some thirty or more lectures before various clubs, organizations and medical societies, these lectures being on public health matters, dairies and dairy conditions or tuberculosis. An effort was made to defeat the proposed manner of disposal of garbage in Los Angeles and have a modern reduction plant installed, but the City Council will renew the old contract and permit the greater part of its garbage to be fed to hogs.

Without in any way infringing on the rights, this committee had made several hundred slides, showing tuberculosis conditions, and in conjunction with the California Association for the Study and Prevention of Tuberculosis, we have taken a part in the organization of Anti-Tuberculosis Societies, south of the Tehachapi Mountains.

The members of this commission residing in Los Angeles County are members of the Los Angeles County Medical Milk Commission and for the year 1908 personally inspected the Certified Milk Dairy at El Monte, and Dr. Black of our commission, made all bacteriological and chemical examinations of milk without cost to the commission. The fees resulting from the certification of this dairy by a vote of the Los Angeles County Society were given to the Medical Milk Commission to be used in public health work; this made it possible for us to secure lantern slides, and defrayed the expenses incident to our public health lectures, at no cost to the State Medical Society.

There has been a large portion of the work of the

Public Health Commission that has been purely educational, and in view of the fact that many of our lectures were public meetings, open to the laity, and in almost every instance there was a large attendance, we feel that some good may come of this work.

We have seen very forcibly that medical legislation of inestimable value to the State is absolutely necessary in the near future, and would recommend that the Legislative Committee of the State Medical Society be enlarged so that it can contain from two to four members in every legislative district, and that work be started immediately. With two years ahead of us, we feel that much could be done in being a factor in this election of our Legislature two years hence. If the policy that has been pursued in the past,—waiting until the legislature convenes and then making a hasty scramble to get two or three of our members to go to Sacramento to lobby against an organized lobby, be continued, we will meet with defeat, as we have done in the past legislature, when the spectacle of some thirty or forty, secured legislation which was opposed by every member of our medical society.

We must organize, and organize at once, and unless we do organize, the medical profession of the State of California will never secure for the State, legislation that is absolutely essential.

The scope of work before the Public Health Commission is simply without limit. The production of unadulterated milk and other sanitary conditions, the prevention of contamination of water supplies of our people, the adequate and sanitary disposal of garbage, wastes and sewage, and prevention of atmospheric pollution by smoke and gases, the erection of sanitary houses and work shops, the supervision by the State of the conditions under which laboring men, women and children work,—these are a few of the problems facing this State along public health lines, and are a few of the problems concerning which your commission has been striving to educate the public and the profession.

The work has been handicapped by lack of funds and the indifference of many of whom we have a real right to expect support. But, the work is a righteous and a needed one, and increased effort can only mean increased success. We believe each year will see better and better results accrue from this organized effort to safeguard the public health interests of our State, and believe also that this Society should pledge itself anew to continue its efforts in these directions.

#### ANNUAL REPORT OF THE COMMITTEE ON TUBERCULOSIS.

GEORGE H. EVANS, M. D., Chairman.

The work of the Committee on Tuberculosis of the Medical Society of the State of California during the past year has not been as productive of results as the committee would have desired. When it held its first meeting, June 2nd, 1908, it was decided that the most useful thing that it could do was to gather all available data in regard to the

prevalence, distribution and causes of human tuberculosis in the State of California. Out here, in this glorious western state, most persons are prone to assume that the majority of dying consumptives are individuals who have traveled from eastern climes, in quest of health, but that their disease was too far advanced for the climate to cure them. Unfortunately, they fail to realize that our natives furnish more victims to this dread disease than do these eastern travelers, and a comprehensive report, it was thought, would do much to awaken all concerned to the realization of these facts.

This sort of report had been found very valuable in Maryland and other states and after a careful study of the situation, we asked your society for financial support in the undertaking. The treasury, we were told, was too poor to allow us the required funds, and we therefore postponed this undertaking until such time as the funds might be forthcoming. We hoped the Legislature might see fit to grant this money, and we therefore had a bill drawn up (Senate Bill No. 63) for the creation of a Tuberculosis Commission, with an appropriation sufficient to cover the cost of gathering the data, publishing, and distributing such report. It was the conviction of your committee that such a comprehensive report was an absolute necessity as a basis for a systematic and broad educational propaganda in a state where, with the exception of Colorado, the highest relative death rate exists of all the registration states.

Recognizing the fact that no great reduction in this death rate could be brought about unless necessary legislation were adopted whereby boards of health could be clothed with the necessary power to provide a comprehensive system of registration, another bill was drawn up by the committee (Senate Bill No. 59) "Defining the Powers, and Duties of Physicians, Local Health Officers and Boards of Health in the Matter of the Protection of the People of the State of California from the Disease known as Tuberculosis, providing for Requisitions and Reports and making an Appropriation therefor." This bill was drawn up after the plan of the New York law which went into effect in that state a year ago, and which has already been productive of splendid results.

Before these bills were introduced into the Senate, your committee consulted the State Board of Health, as well as representatives of the Federal Service. Dr. Foster offered to introduce both measures as State Board of Health bills, and as such did they enter the Senate.

Bill 63 was killed in committee, never reaching the floor of the Senate. Bill 59 came near suffering the same ignominious fate. Thanks to the efforts of Dr. Foster it reached the floor, and here again it would have died had not the committee been warned in time, and protested vigorously against such action, using all their influence to bring about its passage. They succeeded; but to what purpose? The Governor gave notice that he would veto the bill, and all the efforts of the committee were of no avail to hinder his action. This was done under a veto message dated March 16th, 1909, a copy of which is herewith appended:

Executive Department, State of California,  
Sacramento, March 16th, 1909.

To the Honorable Senate of the State of California:

I have the honor to return herewith Senate Bill No. 59—An Act defining the powers and duties of physicians, local health officers, and boards of health in the matter of the protection of the people of the State of California from the disease known as tuberculosis, providing for requisitions and reports, and making appropriation therefor—without my approval for the following reasons:

This Act requires every physician practicing in this state, and every chief officer in charge of any hospital, dispensing asylum, or other private or public institution, to report to the local health officer the name, age, sex, color, occupation, address, and place where last employed of every person having tuberculosis who comes under his care or observation. It is made the duty of every health officer to make microscopical examinations of sputum sent him as that of a person having symptoms of tuberculosis, and he must make a record of all such examinations, which record is not to be divulged, except as may be necessary to carry into effect the provisions of this Act.

Thus far there is no particular objection to the bill, but it proceeds to more radical measures by providing that in the case of the vacation of any apartments or premises by the death or removal therefrom of a person having tuberculosis, the attending physician, or, in his absence, the owner, lessee, occupant or other person having charge of such apartments must notify the health officer, and such place shall not be occupied until disinfected, cleaned or renovated, as provided by the Act. Other provisions provide that if disinfection be not made within forty-eight hours, a notice shall be placed on the door of the premises to the effect that these apartments have been occupied by a consumptive and must not be occupied until disinfected, etc.

While these provisions are designed for the protection of the public health, they are so drastic that they would have a most deplorable effect if carried out in their entirety. The loss of business, and the inconvenience and loss through disinfection, would cause the closing of all doors against consumptives. These poor unfortunates would be unable to obtain lodgings in any place. They would become outcasts, and shelter would be denied them. Not only would they be excluded from all dwellings, but no person could travel with the assurance of receiving shelter unless he could produce a physician's certificate that he was free from tuberculosis. No landlord would rent apartments without the preliminary requirement of a clean bill of health from his prospective tenant.

(Signed) J. N. GILLET,

Governor of the State of California.

The principal alleged objection the executive brought forward in this incomprehensible message was that "while these provisions (disinfection and renovation of infected premises) are designed for the protection of the public health, they are so drastic that they would have a most deplorable effect if carried out in their entirety. The *loss of business*, and the inconvenience and loss through disinfection, would cause the closing of all doors against consumptives."

Careful investigation in most large cities has clearly shown the influence of infected dwellings on the prevalence of tuberculosis. The greatest activity to-day in the crusade against this disease, is the effort to get at the infected centers, the breeding places, and remove the danger. The most malign influence that is attempting to interfere with this work is the criminal greed of the selfish owner of the tenement who uses the very argument of the

chief executive of this great state, in this veto message, so disastrous to the physical welfare and happiness of the people of this commonwealth.

Your committee would earnestly recommend that all local boards of health should immediately endeavor to have enacted ordinances, having for their objects intelligent registration of all cases of tuberculosis in their jurisdiction, and giving such boards discretionary power in matters pertaining to disinfection, renovation, etc.

The committee wishes to take this opportunity of thanking the different organizations for their valuable support in the endeavor to have these bills passed. Every organization to which application was made, gave its endorsement to these measures, with one exception: Bill No. 63 was not endorsed by the State Association for the Study and Prevention of Tuberculosis, as that body informed the committee some weeks later.

The committee refers with much satisfaction to the consummation of its efforts in the organization of the San Francisco Association for the Study and Prevention of Tuberculosis. This body has a large and active membership, with permanent headquarters and extensive office equipment. Its efforts at centralizing the work in that city has been productive of great good. It has completed a series of lectures. It has a central clinic thoroughly organized, with representation from the leading medical institutions of the city, and will, it is expected, in a few months, be in a clinic building of its own, plans of which have been accepted. The development of this Association is proving a great stimulus to those in other localities, Oakland having recently organized an association.

There being no funds at the disposal of this committee for the carrying out of the statistical work contemplated, and as it is believed that the Legislative Committee might take up these bills in two years' time; and further, there being but little advisory work to be done, local societies and the State Tuberculosis Association being now equipped to carry on this work, the committee recommends that it be herewith abolished.

(Signed.)

GEORGE H. EVANS,  
F. M. POTTENGER,  
HERBERT C. MOFFITT,  
C. M. COOPER,  
RENE BINE,

Committee.

#### REPORT OF THE COMMITTEE ON CANCER.

W. F. B. WAKEFIELD, M. D., Chairman.

The committee on cancer beg leave to make the following recommendations:

1. That a Committee on Cancer be made a permanent committee.
2. That 100,000 brochures, for distribution to the public, be printed, setting forth, in simple manner, some plain statements of facts, intended to be educational in character, provided that the committee

succeed in raising the money for the printing of the same.

3. That the committee be given power to act in completing the details of the contents of the brochure and in having the same printed; the completed article to be submitted to the Publication Committee for approval before printing. The rough draft has been made but some finishing touches are required. The committee finds it very difficult to say just enough without saying too much. We thought it wise not to burden the general session with the article in detail, but simply to state that it will consist of about 1000 words pointing out the great mortality from cancer, drawing attention to the necessity for early enucleation, instructing the public in regard to the early signs of cancer of organs most frequently involved, urging them to renounce the idea of cancer being primarily a systemic disease, but to recognize its original localization, and to be honest with themselves in admitting its possibility in every individual and to consult the family physician on the development of any suspicious symptom, however trivial.

4. That the members of the State Medical Society be the distributing agents, the brochures, when printed, being handed over to the Secretary who, in turn, will send them to the different members of the Society with the request that they be judiciously distributed among his or her patients.

W. F. B. WAKEFIELD.  
EMMETT RIXFORD.  
M. H. FISCHER.

#### COMMITTEE ON VENEREAL DISEASES.

A. B. GROSSE, M. D., Chairman.

To the President and Members of the State Medical Society.

\* Your Committee on the prophylaxis of Venereal diseases begs leave to present the following report:

We have communicated with other bodies in the various States and countries working toward the same goal and we have sent the following circular letter to all the County Societies within our jurisdiction, elucidating the principles along the lines of which we deem it essential to proceed.

Board of Education and Labor Organizations have been interviewed, and preparations made for a vigorous campaign.

*The Committee on the Prophylaxis of Venereal Diseases.*

The committee has deemed it most expedient to address the following recommendations to the Secretaries of the various County Societies:

I. We recommend that each County Society arrange for the permanent maintenance of a ward or a certain number of beds in a hospital or similar institution for the care of acute venereal cases. We believe that this quasi quarantine will be a long step in the direction of preventing the spread of venereal infection. Such patients should be confined until it be deemed safe to dismiss them for ambulant treatment.

II. We recommend that each County Society arrange for practical talks on sexual hygiene to the



students of the upper classes of the high schools by competent and judicious physicians.

III. We recommend that the various benevolent lodges and trades unions receive practical talks from selected members of the respective County Societies not only of the dangers of venereal infection but also of the serious interference with the earning capacity of an individual suffering from a venereal infection. Further that common humanity and their own material interests demand that such infected individuals are entitled to and should receive a sick benefit equally with those otherwise so entitled.

IV. We recommend that each member of the medical profession constitute himself a committee of one to disseminate information and advice to his clientele more especially on the possible dangers from venereal infection.

Respectfully submitted,

ALFRED B. GROSSE.

JOHN C. SPENCER.

A. E. OSBORNE.

#### MINUTES OF THE HOUSE OF DELEGATES.

Thirty-ninth Annual Meeting, San Jose, April 20th, 1909.

##### FIRST SESSION.

The House of Delegates was called to order at 9 p. m., Tuesday, April 20th, by the President, Dr. W. W. Beckett. Forty-nine delegates responded at the first roll-call.

The President read the annual address to the House of Delegates.

Moved, seconded and carried that a committee of three be appointed, to which committee should be referred all reports of officers and all matters of new business. Jas. H. Parkinson, W. J. Barlow and T. C. Edwards appointed. President's address referred to this committee.

Report of the Secretary was read and referred to the same committee.

Report of the Council was read and referred to the same committee.

Report of the Committee on Scientific Work was presented and referred to the same committee.

Report of the Committee on Public Policy and Legislation, which had been read at the general session, was referred to the same committee. Dr. Parkinson presented a verbal, supplemental report from the committee, giving the history of various medical bills before the last Legislature.

Report of the Committee on Medical Education, read at the general session, was referred to the same committee.

Report of the Committee on Tuberculosis, read at the morning session, was referred to the same committee.

Report of the Committee on Public Health, read at the general session, was referred to the same committee.

Report of the Special Committee on Cancer, read at the general session, was referred to the same committee.

Report of the Special Committee on Venereal Diseases, read at the general session, was referred to the same committee.

An amendment to the By-Laws, adding to the list of standing committees, Article VI, Section 1, the following, was then introduced: "A Committee on Public Health to consist of five members to be elected annually."

Communication referring to the relief of the widow of the late Major Carroll was read and referred to the same committee.

The minutes were read and approved and the session adjourned to meet April 21st.

##### SECOND SESSION, APRIL 21, 1909.

Election of officers.

Meeting called to order by the President at 9:15 p. m. On the first roll-call 63 delegates responded; 15 more were subsequently noted present.

Place of meeting.—W. F. B. Wakefield and J. A. McKee appointed tellers. Sacramento, Santa Rosa, Long Beach, Stockton and Del Monte were placed in nomination, and on the first ballot received, respectively, the following votes: 28, 17, 0, 29 and 4. The President called for another ballot. On motion, regularly seconded and carried, it was decided to drop the three lowest nominations. On the second ballot Sacramento received 43 votes and Del Monte 34 votes. The President declared Sacramento as the place for next meeting.

President.—Dr. Jas. H. Parkinson, Sacramento, was placed in nomination by Dr. T. W. Huntington. There being no other nominations, on motion the nominations were closed and the Secretary was instructed to cast the ballot of the House of Delegates for Dr. Jas. H. Parkinson for President; carried.

1st Vice-President.—Dr. Wm. Simpson, San Jose, was nominated by Dr. H. Bert Ellis. There being no other nominations, action similar to the foregoing was taken; the Secretary casting the ballot.

2nd Vice-President.—Dr. W. B. Sawyer, Riverside, was nominated by Dr. Griffith; no other nominations; similar action.

Secretary.—Dr. Philip M. Jones was nominated by Dr. Cheney; there being no other nominations, similar action was taken, the President casting the ballot of the House of Delegates.

Board of Examiners.—Dr. John C. Spencer nominated the following: A. S. Lobingier, Los Angeles; G. F. Reinhardt, Berkeley; Walter Lindley, Los Angeles; W. W. Roblee, Riverside; F. R. Burnham, San Diego; W. P. Burke, Highland; C. D. Ball, Santa Ana; J. H. Barbat, San Francisco; A. L. Cothran, San Jose; George H. Evans, San Francisco. There being no further nominations, the same course was taken, the Secretary casting the ballot for the House of Delegates.

Councilor.—First District, vice F. R. Burnham. Dr. Fred Baker was nominated by Dr. Magee; Dr. G. G. Moseley was nominated by Dr. Strong. On a ballot being taken, the President announced the election of Dr. Baker.

Third District.—Dr. T. C. Edwards was nominated to succeed himself by Dr. Saxton Pope. No other nominations; similar action.

Fourth District.—Dr. Geo. H. Aiken was nominated to succeed himself by Dr. J. R. Walker; no other nominations; similar action.

At Large.—Dr. H. A. L. Ryfkogel was nominated to succeed himself by Dr. C. G. Kenyon; no other nominations; similar action.

Eighth District.—Term expires 1910, vice Jas. H. Parkinson. Dr. W. A. Briggs was nominated by Dr. J. A. McKee; no other nominations; similar action.

Committee on Scientific Work.—The following were nominated: H. R. Oliver, W. H. Gibbons, H. A. Alderson and L. Schmitt. No other nominations; similar action.

Committee on Public Policy and Legislation.—The following were nominated: O. D. Hamlin, G. MacGowan, J. A. McKee; no other nominations; similar action.

Committee on Arrangements.—The following were nominated: A. M. Henderson, S. E. Simmons and J. W. James; no other nominations; similar action.

Committee on Public Health.—George H. Evans, George H. Kress, S. P. Black and W. F. Snow were nominated; no other nominations; similar action.

Delegates to the A. M. A. for two years.—H. Bert

Ellis and Granville MacGowan were nominated; no other nominations; similar action.

Alternates to the A. M. A.—W. W. Beckett, Thos. W. Huntington and W. LeMoyné Wills were nominated; no other nominations; similar action.

Delegate to Darwin Celebration.—Dr. A. L. Lengfeld.

Reference Committee then reported by its chairman, Dr. Parkinson. The report was first read in full. It was then read section by section and adopted as follows:

Joint Legislative Committee.

Committee recommends: 1. That a joint legislative committee consisting of the legislative committees of the different branches of the profession represented under the present medical law, be organized, said committee to meet prior to and when necessary during sessions of the Legislature to consider medical bills that may be introduced and to formulate a policy of action.

Representatives in the Legislature.

2. That such legislation as this committee deems necessary be prepared and introduced by a representative in each house who shall have charge of such measures.

Medical Legislators.

3. That a determined effort should be made by the various County Societies to elect members of the profession to Senate and Assembly, always bearing in mind that such physicians must not only be well qualified and of good standing in the profession, but also capable of dealing with men and with affairs. Committee on Medical Education. Publication of Investigations.

4. That the Board of Examiners should publish the results of their investigations of colleges in the State and recommends that its representatives on the board be so instructed.

Report from the Board of Examiners.

5. While recognizing that the Board of Examiners can report only to the Governor, your committee advises that an annual report to this society be requested from our representatives.

Naturopathic Certificates.

6. That our representatives on the Board of Examiners be instructed to closely scrutinize the credentials of all holders of naturopathic certificates applying for licenses in excess of the number specified by their representatives at joint conferences.

Popular Lectures.

7. That lectures designed to familiarize the laity with medical and sanitary questions be provided and that such lectures can be best given under the auspices of County Societies in their respective districts. Committee on Tuberculosis.

8. In accordance with the request of this committee, we recommend that it be discharged, the work now being performed by the State Association.

Committee on Public Health. Certified Milk.

9. Believes that the best solution of the milk problem in the campaign for a better supply is certified milk and recommends that the doctrine of certified milk be preached to the public and urged before the local Health Boards throughout the State. Central Health Organization.

10. That a strong Central Public Health organization is most desirable and that this committee be charged with the duty of bringing same about, to the end that organizations working for similar purposes may affiliate and meet in joint session prior to the annual meetings of the Society.

Committee on Cancer.

11. Recommends that this unique report, the like of which was never before presented to this Society,

be adopted as read and that the committee be continued.

Committee on the Venereal Peril.

12. Recommends this report to the careful consideration of the County Societies and that the committee be continued.

Report of President to House of Delegates. Increase in Membership.

13. That as a decided increase in membership is desirable the President's suggestion on this subject be conveyed to the various County Societies.

Sanitation Car.

14. Believes that the usefulness of the "Sanitation Car" might be greatly extended were arrangements made for pitching a tent adjacent to the car so that the exhibits could be seen to better advantage.

Education of the Public.

15. That education of the public is best effected through the local societies and recommends that this matter be urged upon them.

Delegates to American Medical Association.

16. Recommends that no member should permit himself to be elected as delegate or alternate to the A. M. A. unless it be his present intention to attend the meeting.

Medico-Legislative Organization.

17. Recommends that legislative committees be appointed by every local society in senatorial districts and that wherever possible the members should be selected from men having had political experience, such committees to work through the secretaries of their respective societies who in turn shall report to the Secretary of the State Society, the latter officer dealing directly with the Committee on Public Policy and Legislation.

Governor Gillett.

18. Recommends that the thanks of the Society be extended to Governor James N. Gillett for his efficient services in connection with Public Health Legislation.

Report of Secretary. Society's Note.

19. Recommends that the Society's note for \$2000 be taken up by the issuance of 20 notes of \$100 each. Records of Legislators.

20. Endorses the proposition to furnish the various County Societies with the records of their legislative representation on public health laws.

Better Papers for the Journal.

21. Recommends that the Secretaries of local Societies inform the editor of the Journal, in advance, of papers that may be read at their meetings so that when desirable same may be procured for publication. Annual Assessment.

22. That the assessment for the coming year be fixed at \$3.00.

Report of President of Council. Secretary's Salary.

23. Recommends that the council, when the income of the Society shall justify same, restore the Secretary's salary to the amount obtaining in 1908. Quarterly Register.

24. Believes that the publication of a quarterly register is not desirable at the present time.

Committee on Scientific Program. Special Work Original Investigation.

25. Recommends that the Secretaries of the various local Societies be requested to inform the chairman of the Committee on Scientific Work as to men who may be engaged in special work or in original investigation so that the best material may be procured for the annual meetings.

Acceptance and Rejection of Papers.

26. Recommends that an increased discretion be

given the Program Committee in the acceptance or rejection of papers having in mind the fact that it is only possible to dispose of a limited number of papers at sessions and at the same time permit of intelligent discussion.

Ten Minute Papers.

27. Your committee submits the suggestion that the limit of ten minutes now advised for papers be made a part of the by-laws without recommendation.

Mrs. Carroll.

28. Recommends that the Secretary be instructed to receive subscriptions for this worthy object.

American Medical Benevolent Association.

29. In this connection your committee recommends that our delegates to the A. M. A. be instructed to urge the formation of an American Medical Benevolent Fund in connection with the Association, on the same lines as the British Medical Benevolent Fund.

JAMES H. PARKINSON.  
W. JARVIS BARLOW.  
T. C. EDWARDS.

Instructions to Delegates.—It was moved by Ellis, duly seconded and carried, that the delegates to the A. M. A. be instructed to endeavor to secure the meeting of the Association in 1910 at Los Angeles.

The amendment to the By-Laws, introduced at the previous session, was adopted.

Communication relating to new Councilor District was read and on motion referred to the Council.

Communication (verbal) from Dr. Hildreth for Dr. W. S. Fowler, Chairman of the special Committee on Medical Defense, and prevented from being present, was referred to the Council.

Moved by Dr. T. C. McCleave, regularly seconded and carried, that when the House of Delegates adjourn it do so in memory of our distinguished late President, Dr. Frank L. Adams.

Moved, seconded and carried (motion put by the Secretary) that the thanks of the House of Delegates be extended to Dr. W. W. Beckett for the tact and courtesy with which he had conducted the sessions of the Society.

Moved, seconded and carried that the thanks of the Society be extended to the Santa Clara County Medical Society, to the ladies of San Jose and to the medical profession of San Jose for the magnificent reception and entertainment they have extended to the Society.

The President, Dr. Jas. H. Parkinson, was then escorted to the chair and introduced. He made a few remarks, after which the minutes were read and approved as read.

The Society then adjourned sine die.

PHILIP MILLS JONES, Secretary.

#### DELEGATES PRESENT, SAN JOSE MEETING.

W. L. Emerson, H. N. Rowell, G. F. Reinle, Dudley Smith, W. O. Smith, T. C. McCleave, E. F. Gatchell, J. R. Walker, D. H. Trowbridge, H. Hildreth, W. E. Hibbard, A. Soiland, J. Y. Oldham, S. P. Black, W. H. Kiger, H. B. Ellis, W. H. Roberts, W. Le M. Wills, F. Miller, W. J. Barlow, D. Fulton, G. W. Lasher, E. W. Fleming, H. G. Brainard, John H. Kuser, J. L. McClelland, H. B. Christiansen, F. Chaffee, Thos. R. Griffith, S. E. Simmons, A. M. Henderson, J. A. McKee, D. C. Strong, T. L. Magee, H. P. Newman, V. G. Clark, W. F. B. Wakefield, H. Morrow, J. C. Spencer, H. Brunn, R. L. Porter, R. Russ, G. E. Ebright, Dudley Tait, F. B. Carpenter, S. J. Hunkin, T. W. Huntington, A. Weeks, W. F. Cheney, H. D'A. Power, C. G. Levi-son, C. M. Cooper, A. A. O'Neill, E. Schmoll, H. R. Oliver, M. R. Gibbons, R. L. Rigdon, G. B. Somers, W. S. Franklin, B. J. Powell, A. W. Hoisholt, H. M. Cox, H. C. McClenahan, Wm. T. Barry,

W. F. Snow, J. N. Hall, H. J. B. Wright, J. L. Asay, S. T. Pope, R. T. Legge, J. J. Hogan, G. W. Mallery, W. E. Bates, H. D. Lawhead.

#### MEMBERS REGISTERED AT THE SAN JOSE MEETING.

Asay, J. L., San Jose; Avey, John L., Redlands; Atkinson, A. T., San Jose and San Francisco; Arnold, J. Dennis, San Francisco; Aiken, Geo. H., Fresno; Alexander, E. W., San Francisco; Avery, Caroline, San Jose; Alderson, Harry E., San Francisco; Arthur, E. A., Stockton; Abrahamson, Milton, San Francisco.

Birtch, Fayette W., San Francisco; Beckett, Wesley W., Los Angeles; Black, S. P., Los Angeles; Barbat, J. H., San Francisco; Barlow, W. Jarvis, Los Angeles; Barry, William T., Santa Barbara; Bates, W. E., Davis; Brumwell, D. A., King City; Belknap, L. J., San Jose; Briggs, Leroy H., Oakland; Buteau, S. H., Oakland; Benzinger, Z., Oakland; Burnham, F. R., San Diego; Brown, Rexwald, Santa Barbara; Browning, Ferdinand W., Hayward; Bew, Lolita Day, San Francisco; Burke, E. W., Highland; Brow, H. C., San Jose; Bering, R. E., Tulare; Beneke, J. L., San Jose; Butin, Mary R., Madera; Briggs, Wm. E., Sacramento; Briggs, W. A., Sacramento; Brainard, H. G., Los Angeles; Brunn, Harold, San Francisco; Barbat, Wm. F., San Francisco; Bishop, T. W., South Pasadena; Belknap, Florence A., San Jose; Brown, Philip K., San Francisco; Bull, C. George, Alameda.

Cole, Elsie W., Berkeley; Cohn, Robert D., San Francisco; Carpenter, F. B., San Francisco; Crees, Robert, Lakeport; Cox, H. M., San Luis Obispo; Christianson, H., Salinas; Crumpton, H. J., Sausalito; Chaffin, F., Yountville; Caldwell, Robert, San Jose; Cothran, A. Lincoln, San Jose; Cheney, W., San Francisco; Clark, W. A., Alameda; Cameron, Howard, Reno, Nev.; Castle, H. Edw., San Francisco; Clark, Jonas, Gilroy; Clark, V. G., San Diego; Chambers, W. E., Oakland; Curdts, C. E., Oakland; Cooper, C. M., San Francisco; Cooper, J. H., Mountain View; Card, E. F., Oakland; Cadwallader, R., San Francisco; Crowley, D. D., Oakland; Clark, Austin, Alameda; Channell, W. L., Oakland; Conner, A. W., San Jose; Conner, Ada Scott, San Jose; Crosby, Daniel, Fruitvale.

Dael, H. S., U. S. Navy; Deane, Louis C., San Francisco; Dietz, H. L., Oakland; Dozier, Chas. A., San Francisco; Dawson, J. D., Stockton; Dukes, Chas. A., Oakland.

Ellis, H. Bert, Los Angeles; Ewer, Edw. N., Oakland; Evans, Geo. H., San Francisco; Emerson, M. Lewis, Oakland; Enos, M. H., Oakland; Evans, J. H., Hyland; Eastman, F. M., Berkeley.

Frasse, Irvin N., Los Angeles; Foster, N. K., Sacramento; Fischer, Martin H., Oakland; Franklin, Walter S., San Francisco; Follansbee, Elizabeth A., Los Angeles; Fraser, W. W., San Jose; Fredrick, N. W., San Francisco; Fleming, E. W., Los Angeles; Fry, P. B., Benicia; Fulton, Dudley H., Los Angeles; Frankenhimer, Jules B., San Francisco; Fritsch, A. N., San Francisco; Frisbie, E. G., San Francisco.

Griffeth, T. R., Riverside; Greene, Frances M., Berkeley; Gillihan, Allen F., Berkeley; Grimes, Warren V., Pacific Grove; Gunn, Herbert, San Francisco; Gatchell, Ella F., Chico; Gates, Howard B., San Jose; Gates, Amelia L., San Jose; Gallimore, Elizabeth, San Jose; Gibbons, Morton R., San Francisco; Green, Jacob S., Alameda; Gross, R., Eureka; Galbraith, A., Oakland; Greenwood, Edna M., San Francisco; Grissim, J. D., Oakland; Grosse, A. B., San Francisco.

Holt, Wm. L., Santa Barbara; Hogan, Jas., Vallejo; Hoisholt, A. W., Stockton; Hastings, Hill, Los Angeles; Henderson, A. M., Sacramento; Harker, Geo. A., Oakland; Horthington, Geo. B., Marysville;



Hildreth, H., Delano; Hamlin, O. D., Oakland; Huntington, T. W., San Francisco; Hervey, C. H., San Jose; Hodghead, D. A., San Francisco; Hall, J. Underwood, San Jose; Hunkins, Sam, San Francisco; Hibbard, H. C., Los Angeles; Hyde, O. C., Oakland; Hull, Jack, Stockton; Harbrit, Ellis, .....; Hopkins, M. F., San Jose.

Kenyon, C. G., San Francisco; Kuser, J. F., San Rafael; Kress, George H., Los Angeles; Koford, Henning, Oakland; Kiger, W. H., Los Angeles; Kune, J. M., Oakland; Krone, C. R., Oakland; Kapp, M. W., San Jose; Keck, Josiah H., Palo Alto; Kocher, J. J., San Jose; King, Gus C., Banning; Knorp, Francis F., San Francisco.

Langdon, S. W. R., Stockton; Lucas, William T., Santa Maria; Lyon, S. B., San Jose; Levison, C. G., San Francisco; Lafontaine, Emma C., San Francisco; Lobingier, Andrew S., Los Angeles; Liverman, J. R., San Bernardino; La Spada, Francesco, San Jose; Legge, Robert T., McCloud; Lilley, W. E., Merced; Lee, Helen, San Francisco.

MacGowan, G., Los Angeles; Mattison, F. C. E., Pasadena; Miller, John J., San Jose; McClelland, J. L., Merced; Morton, A. W., San Francisco; Manson, P. M., Fresno; Meeker, J. A., Sacramento; Musser, Frances R., Oakland; McClury, Katherine, Oakland; Maturaki, E., Oakland; Morrison, T. K., Reno, Nevada; Marvin, G. T., Agnew; McGavern, H. S., Sacramento; Miller, Frank W., Los Angeles; Maloney, M., San Francisco; Mallory, G. W., Santa Rosa; Moyer, J. J., Mayfield; Morrow, Howard, San Francisco; Mace, L. P., San Francisco; Magee, Thomas L., San Diego; McMahon, J., San Jose; McCleave, T. C., Berkeley; McGinty, Arthur, San Jose; McLaren, J. L., Oakland; Martin, H. R., Riverside; Milton, J. L., Alameda; McNutt, W. F., San Francisco; McGahn, Mary R., Sunnyvale; McClenahan, H. C., Belmont; Mead, L. D., San Francisco; Moore, W. G., San Francisco; McCresney, Geo. T., San Francisco; Mulcahy, M., San Jose; Martyn, J., Los Angeles; MacMonagle, Beverly, San Francisco; Meyer, Henry, San Francisco.

Norse, Alfred B., San Francisco; Newman, H. P., San Diego; Nagai, Gen, Berkeley; Nusbaumer, Pauline O., Oakland; Newell, Edward, San Jose.

Osborne, A. E., Santa Clara; O'Neill, Arthur A., San Francisco; Oldham, John Y., Los Angeles; Oliver, H. R., San Francisco; Orr, Jane, Oakland; Orbison, Thos. J., Los Angeles; Orme, Henry S., Los Angeles.

Pottenger, F. M., Los Angeles; Pomeroy, Geo. T., Oakland; Parkinson, J. H., Sacramento; Powell, Barton J., Stockton; Pischel, Kaspar, San Francisco; Park, H. C., San Jose; Power, H. D., San Francisco; Bond, H. M., Alameda; Pope, Saxton T., Watsonville; Peterson, F. H., San Jose; Porter, R., San Francisco; Page, Clarence W., Alameda; Peers, Robert A., Colfax; Peck, Allan H., Palo Alto; Pettersen, F. W., El Centro; Paul, J. W., Santa Clara; Painter, G., San Francisco; Porter, Wm. S., Oakland; Parsegan, J. H., San Francisco.

Reinhardt, G. F., Berkeley; Rogers, F. L., Long Beach; Ryfkogel, H. A. L., San Francisco; Regansburger, Martin, San Francisco; Rothganger, George, San Francisco; Russ, Raymond, San Francisco; Rowell, Herbert N., Berkeley; Roberts, W. H., Pasadena; Roblee, W. W., Riverside; Reinle, Geo. L., Oakland; Rigdon, R. L., San Francisco; Richards, Chas. M., San Jose, Cal.; Rosenberg, Caroline, San Francisco; Robinson, J. W., Livermore; Rowe, Chas. H., Oakland; Rothschild, M., San Francisco.

Strong, D. C., San Bernardino; Snow, William F., Stanford University; Simpson, Wm., San Jose; Smythe, Margaret H., Stockton; Silvia, Clara A., Gilroy; Shannon, J. M., Oakland; Sampson, May H., Berkeley; Selfridge, Grant, San Francisco; Stoddard, T. A., Santa Barbara; Soiland, Albert, Los Angeles; Simmons, S. E., Sacramento; Sampson, A. F., San Francisco; Sampson, J. H., San Jose; Short-

ridge, C. D., San Francisco; Somers, Geo. B., San Francisco; Shuey, Sarah I., Oakland; Selling, Nathalie, San Francisco; Stratton, R. T., Oakland; Stephens, W. D., San Francisco; Stephens, J. M., San Francisco; Stillman, Stanley, San Francisco; Sill, Edward R., Oakland; Sewall, Edward C., San Francisco; Spencer, John C., San Francisco; Spalding, Alfred B., San Francisco; Smith, W. O., Alameda; Simpson, J. A., San Francisco; Sherman, H. M., San Francisco; Sanderson, A. J., Berkeley; Schunole, R., San Francisco; Schmitt, F. S., San Francisco; Seibert, F. M., San Mateo; Smith, Dudley, Oakland; Seymour, James H., San Francisco.

Taltavall, Wm. A., Redlands; Tait, F. D., San Francisco; Taylor, W. S., Livermore; Trowbridge, W. H., Fresno; Terry, Wallace I., San Francisco; Tebbe, Fred H., Weed; Trew, Niel C., Los Angeles; Thomas, Benjamin, San Jose; Thomas, Hayward, Oakland; Teass, C. J., Shasta; Trueman, J. E., San Jose.

Van Orden, Dorothea, Berkeley; Von Adelung, Edward, Oakland; Van Orden, Kate P., Alameda; Veeki, V. G., San Francisco; Van Winkle, T. W., San Francisco; Van Zwahlenburg, C., Riverside.

Witter, G. F., San Jose; Wanzer, Lucy F. M., San Francisco; Wagner, H. L., San Francisco; Wakefield, W. F. B., San Francisco; Walker, J. L., Fresno; Wagner, E. R., San Jose; Wright, H. J. B., San Jose; Wintermute, G. P., Oakland; Wakefield, W. H., Oakland; Wilbur, R. L., Palo Alto; Witty, W. F., San Francisco; Walker, Agnes, San Francisco; Wills, W. L., Los Angeles; Wislocki, W. E., San Jose; Weeks, A., San Francisco; Whiffen, R. A., San Jose; Walter, Chas. H., San Jose; Watkins, J. T., San Francisco; Wilson, D. R., San Jose; Wilder, C. H., Oakland; Walker, B. F., Stockton; Wayland, C. A., San Jose; Wanden, C. C., Los Angeles; Wemple, C. L., San Francisco.

## NOTICE.

We are going to try to issue the Register and Directory in July, this year. Will you please send in your own or any other change of address known to you. The accuracy of the work largely depends upon the co-operation of the members.



WESLEY W. BECKETT, M. D., PRESIDENT 1908, 1909.

Dr. Beckett was born in Portland, Oregon, on May 31st, 1857. When about three years old he came with his parents to California and has lived in this State ever since. He received his education from the public schools, and in 1888 was graduated by the Medical Department of the University of Southern California. He then spent a year in the New York Post Graduate Medical School and Hospital, eventually returning to Los Angeles, which city he has made his home ever since. Of late years Dr. Beckett has devoted his attention entirely to surgery. He is a member of the Los Angeles County

Medical Society, Los Angeles Clinical and Pathological Society, Southern-California Medical Society, Medical Society of the State of California and American Medical Association; ex-President Los Angeles County Society, Los Angeles Clinical and Pathological Society and Southern California Medical Society; ex-member of the Board of Health of the City of Los Angeles; Professor of Gynecology in the Medical Department of the University of Southern California. Dr. Beckett was elected President of the State Society at the meeting in April, 1908, and presided at the sessions at San Jose, April, 1909.

ADDRESS OF WILLIAM T. BARRY, M. D.,  
TO THE SANTA BARBARA COUNTY  
MEDICAL SOCIETY, UPON RETIRING  
FROM THE CHAIR, JANUARY 8, 1909.

I can not lay down the gavel, which I have held for the past year, without thanking the members of the Santa Barbara County Medical Society for the kind support which they have given my administration. The rulings of the chair may at times seem arbitrary, but I have always aimed to be just while keeping within parliamentary law. On taking the chair a year ago I announced my policy in the following words:

"My plan throughout the year shall be to co-operate with the secretary and program committee in making our monthly meetings bright, fresh, entertaining and instructive. I propose also to call from time to time, certain special sessions to meet and listen to some of the more eminent members of our profession, or to discuss such special matters as can not be properly entered into at our monthly meetings."

How far I have been enabled to live up to this policy is for you to judge, as all is now a matter of history. But I am sure that those who have faithfully attended our monthly meetings will agree with me in saying that they have always found them instructive, and that the discussions have resulted in practical professional improvement. In regard to my plan to bring to Santa Barbara some of the more eminent members of our profession, and give you an opportunity to listen to them, I claim that in a very fair measure I have redeemed this promise, as the minutes show this Society has entertained the following gentlemen from a distance:

In May, James H. McBride, M. D., of Pasadena, favored the Society with an instructive paper on Neurasthenia.

During September we had with us Dr. Wesley W. Beckett, president of the State Society, who spoke on Post-Operative Treatment; also the same evening we listened to a paper read by Dr. Ethel L. Leonard of Los Angeles on the Practical Working of the Opsonic Index.

Then in October Dr. Philip King Brown of San Francisco presented a good paper on Physical Therapy in Chronic Heart Disease.

And finally in November, the Society entertained Dr. N. K. Foster, Secretary State Board of Health, who took up the subject of State and Municipal Sanitation and Health. (Dr. Rupert Blue of Marine Hospital Service, was to have been present with Dr. Foster and presented Bubonic Plague, but was kept away by urgent professional business. He has promised us a visit later.) Also at the November meeting we had with us the Rev. Clarence E. Webb, Superintendent Pacific Purity Association, whose remarks on the Venereal Peril were well received.

In addition to the above, in connection with our regular monthly meetings, I had the pleasure of arranging the following special sessions:

On September 15th we held a public session in the assembly room of the High School, which was

addressed by Dr. Philip Mills Jones of San Francisco, the State Secretary of California Medical Society, on Public Health and Legislation, Dr. Beckett appearing with him on the platform.

Later in the fall another public meeting of the same character (on educational lines) was held at the High School, and addressed by Dr. Rexwald Brown on the important subject of Vaccination.

And lastly, in January, Dr. Charles C. Browning of Monrovia delivered at the High School under the auspices of the Santa Barbara County Medical Society a most important and instructive lecture illustrated by stereopticon on the Prevention of Tuberculosis (the immediate result of this lecture was the formation of a branch society for the Study and Prevention of Tuberculosis, of which Dr. Flint is the chairman).

I earnestly trust that my successor will continue this series of public lectures on educational lines so auspiciously commenced.

Nor was the social side entirely forgotten by the Society during the past year. An informal banquet and reception was given in honor of our worthy President, W. W. Beckett, M. D.; a function in the way of a Spanish lunch out in Montecito, to our active and efficient State Secretary, Philip Mills Jones, M. D.; and a lunch at Arlington hotel to Dr. C. C. Browning.

Our Society has grown during the past year, adding the following names to the roll: Doctors Hurst, Holt, Stoddard, Jr., and Lewis of Santa Ynez, also Dr. Philip A. Sheaff, who comes in this evening.

The year 1908 has seen come into existence a permanent Medical Milk Commission, a Venereal Committee, and a committee on organization for the Study and Prevention of Tuberculosis.

I desire to thank publicly the retiring Secretary, Dr. David A. Conrad for his efficient co-operation, and the different committees who assisted in making the Society business run smoothly. And I must commend the active and aggressive work done by Dr. T. A. Stoddard, the present Chairman of the Committee on Public Health and Legislation.

But gentlemen, let us not pause too long or congratulate ourselves unduly on our past successes; a new year lies before us and there is much to be done. We all need to advance scientifically and when feasible we should meet twice a month, and each should ungrudgingly give of his time and talents for the benefit of his fellows.

The profession needs to be more firmly united, and to this end personal enmities should be nobly laid aside.

We need to be more active in resisting the attacks of the enemies of legitimate medicine, the abortionist, the charlatan, the quack, also the foes of preventive medicine, the anti-vaccinationist, and the anti-serumist, Christian Science and the religious fanatic. I am convinced that a certain and proper portion of our deliberations should be given to the press, and to gain this point I appointed a press committee which has done some good work. In my address at the beginning of the year I was bold enough to suggest that this Society own and operate



its own hospital, also that we should own our own building to include a meeting room, a library and a museum. And whereas, any of these are still far from being in sight, I still continue to recommend them.

And now I am resigning the chair to an earnest and capable gentleman, Dr. Eugene A. Dial, for whom I bespeak your united support and hearty co-operation. I am only sorry that I have not proved myself more worthy of the honorable position I am relinquishing. Gentlemen, I thank you.

### INTESTINAL OBSTRUCTION.\*

By CHAS. G. LEVISON, M. D., San Francisco.

Were it not for the fact that the death rate in operations performed for the relief of acute intestinal obstruction has remained unchanged during the past twenty years, I should hesitate to present so threadbare a subject for your consideration. As a result of the cooperation of the physician and the surgeon, the mortality in appendicitis, ectopic pregnancy and typhoidal perforation, has diminished to a remarkable degree, and it is with the hope that a similar understanding may be brought about in the early treatment of ileus, that this paper is presented.

The symptom complex of bowel obstruction, constitutes the most serious and the most dreaded condition that is encountered in the domain of surgery, and it is largely due to the fact that the patient is referred for operation only after all of the remedial measures have been exhausted, and when his resistance is so reduced that it is almost nil. An individual with the distended abdomen of an advanced ileus and the poisoning caused by the absorption of toxins from the intestinal tract, frequently dies soon after operative interference from heart paralysis, despite all efforts at stimulation.

**Mortality.** In an article presented to the New York Surgical Society, January 22, 1908, Elsberg<sup>1</sup> makes the statement "That despite the advance in methods and technic, the mortality after operative interference in acute intestinal obstruction is still very high." In the hands of different operators he states that the mortality varies between fifty and seventy per cent. Of one hundred cases treated by operation during 1906 in three large hospitals in New York City, fifty-four per cent died. Ranzi<sup>2</sup> has collected 758 cases from the literature with a mortality of fifty-seven per cent. Other reports give a still larger death rate. The majority of these patients were seen in an advanced stage of obstruction, relatively few having come to operation at a time when relief of the obstruction was well borne. Elsberg<sup>3</sup> states that in many cases this was due to the difficulty experienced in making an early diagnosis, sometimes to delay on the part of the patient and other times to the very rapid progress of the symptoms. He also remarks "That even if the very advanced cases, those 'in extremis' were to be excluded, that the mortality after operation for acute intestinal obstruction would still give a death rate

\* Read before the San Francisco County Medical Society, August 11, 1908.

of at least from thirty to forty per cent." This mortality can be reduced only by improvements in diagnostic methods, so that it becomes possible to refer these patients to the surgeon at an earlier period. From an operative standpoint the number of failures can only be diminished by greater simplicity in operative manipulations.

Hesse<sup>4</sup> in an exhaustive paper, has compiled statistics which show what a grave and serious condition the acute intestinal obstruction in consequence of a strangulated hernia, really is. From Hesse's statistics, it appears that the mortality averages about fifty-five per cent in gangrenous strangulated hernia. They show that in 1500 cases of operation performed by fifty-nine operators, to relieve this condition, that the death rate has not varied much during the past twenty years. This goes to prove how little the mortality can be influenced by operation when patients are allowed to become toxic as a result of delay.

**Classification.** In the "Schlange" classification<sup>5</sup> of acute intestinal obstruction, two main divisions are given: the dynamic or paralytic ileus; and the obturation or mechanical ileus. The ileus of peritonitis represents the type of the paralytic ileus. The following condition which recently came under my observation was a good example of a bowel obstruction in consequence of an involvement of the central nervous system. It occurred in a healthy man forty-five years of age whose previous history was unimportant. He was seized with an intense headache which did not respond to treatment. All purgatives were without effect and for ten days there was no evacuation of the bowels. He then became unconscious and died a fortnight later of a basal tuberculosis meningitis.

In the second group the conditions are found which produce a mechanical obstruction such as kinks, adhesions, bands, tumors, volvulus, foreign bodies, etc.

With this classification kept in mind the diagnosis of ileus is often facilitated.

**Diagnosis.** Text books and tradition have established a belief in the minds of many physicians that the diagnosis of an incipient ileus is simple and that the condition is easily recognized by classic symptoms. This belief must be eradicated before we shall be able to treat these patients with even a modicum of success.

Writers, as a rule, do not distinguish between an early and a late obstruction, but only state that the condition is associated with great distention; that the peristalsis is evident through the abdominal wall; that the outline of the gut can usually be recognized on the surface of the abdomen; that there is absolute constipation; that the patient cannot pass flatus; that there is always vomiting and that the facies hippocratica is usually present. They also state that indicanuria is always present when the obstruction is high up, and that cachexia is present when a malignant growth exists.

An analysis of the following symptoms together with the history of appropriate cases will not be out of place here.

**Distention.** This is present in all cases late in their development; more especially when the obstruction is low down; when it is higher up as in the small intestine, the distention appears earlier, but not to the same degree that it does when it is in the sigmoid, for example. When distention is present it is always associated with toxemia which is the principal factor in reducing the resistance of the patient. Operation should not be delayed until the appearance of a general distention, as the most favorable moment for operation has passed by the time that this has appeared.

**Constipation.** Occasionally with a complete ileus, it is possible to obtain evacuations by means of enemata; this, however, should not deceive the physician. Even diarrhea may be present occasionally.

A warning must be uttered here against the continuous administration of purgatives when once bowel obstruction is suspected, for these remedies only have the effect of filling the intestine with fluid rich in bacteria, the same being an important factor in the production of the toxemia. When a true ileus is present, catharsis is futile, and when it is absent, temporizing is not associated with danger.

**Flatus.** Retention of flatus is one of the most important signs of bowel obstruction and the diagnosis of this condition is generally based upon the fact that it cannot be expelled; flatus, however, is occasionally passed in the presence of an apparently complete ileus. The following case which recently came under my observation occurred in a woman with a carcinoma of the sigmoid. On the morning of the operation she passed several stools, the result of enemata; she also expelled some flatus. On this account it was felt that an ileus was not present. At the operation the sigmoid was resected and it was found to be completely occluded. After its removal, when the gut was filled with water, not a drop of fluid escaped.

A similar condition occurred in a child in whom diagnosis of ileus had been made. The patient presented all the signs of a bowel obstruction and had been prepared for operation; an enema which was given on the table produced a bowel movement accompanied by the expulsion of some flatus. Naturally the child was put back to bed, for it was presumed that the ileus had been relieved, but through an error I was not informed that the condition had remained unimproved and at the evening visit when I had expected to find the patient better, he was found to be moribund. At autopsy the ileum was found to be obliterated at its lower end by a benign adenoma.

**Visible peristalsis.** This is frequently not discernible on account of the presence of thick abdominal walls, and it should only be accepted as a symptom of value when present.

**Vomiting.** This is almost always present when the obstruction is high up, but only appears late in the history of the condition when the obturation is low down. Cases of involvement of the sigmoid are not necessarily associated with vomiting until

late in their progress, when the period for successful surgery has already passed, so that the absence of this symptom must not eliminate the possibility of the presence of an ileus. I recall the history of a woman in the last stages of Bright's disease with a strangulated umbilical hernia involving the small intestine, who died without a suggestion of vomiting. At autopsy the gut was found to be completely occluded.

**Facies hippocratica.** This symptom is frequently present, but there are many cases in their early history that I have seen where the pinched classic appearance has been absent. This sign of course appears when the patient is almost moribund and when the time for successful operation has passed.

**Indicanuria.** The presence of indican in the urine is also a point upon which considerable stress is laid in determining the situation of the obstruction. Text books state that when the obstruction is high up in the bowel, the output of indican in the urine is much increased, and the opposite obtains when the obstruction is low down. In my experience this has not been found to be the case, for I have observed small quantities of indican present with an obstruction high up, and large quantities when the obstruction was low down in the bowel, consequently I no longer examine the urine for indican, because of the uncertain value of this reaction.

**Cachexia** is frequently absent in the presence of a malignant growth, so that no particular value should be attached to this sign. We have all seen advanced cases of carcinoma of the uterus and the intestine, as well as ulcerating carcinoma of the breast, occur in fat women with rosy cheeks, who have presented no sign of disturbance with their nutrition.

**ACUTE BOWEL OBSTRUCTION.** The diagnosis of an acute ileus caused by a strangulated hernia, is comparatively easy under ordinary conditions, because it is usually associated with pain at the hernial orifice and it is often possible for the patient to make a correct diagnosis himself. It is important, however, not to overlook the fact that a strangulated hernia may still be present even though the hernial ostium is patent. A case of this kind came under my observation, where a healthy man was brought into the hospital with all the symptoms of an acute ileus; he gave a history of having an oblique inguinal hernia. Upon examination, the inguinal canal, which was very large, was found to be empty, so that a strangulated hernia was excluded as being the etiological factor in the ileus. Exploration revealed a strangulated intestine in the extreme tip of the hernial sac which had been reduced "en masse." The inverted hernial sac had extended some four inches into the abdominal cavity and at its tip had strangulated the small gut.

Writers upon this subject state that when a hernia exists and the symptoms of ileus are present, the rupture is almost always found to be the cause of the obstruction. This may be correct up to a certain point but it is important not to discontinue

the search for the obstruction because the hernial opening has been found free. A condition of this nature occurred in my experience in a patient who was suffering from an umbilical hernia with the symptoms of bowel obstruction. At operation the hernial opening was found to be patent and upon continuing the search a carcinoma of the ileum was discovered.

**CHRONIC BOWEL OBSTRUCTION.** The recognition of a chronic bowel obstruction is of great importance for the reason that it is frequently possible to establish the diagnosis of an incipient ileus long before it is complete and it is to *this* point that I desire to attract your attention particularly. As I have stated before, the acute ileus is generally recognized, but in a slowly developing obstruction of the bowels not enough attention is paid to the symptoms which are sufficiently positive to give ample warning and it is at this stage that the best results from surgery can be achieved. A patient who is developing a chronic obstruction of the bowels most frequently complains of recurring gas pains (cramps). In the beginning he is able to expel the flatus without difficulty, but he gradually accomplishes this with less and less success. He complains of the gas pains passing up and down, this symptom being confined usually to a certain part of the abdomen. These pains are intermittent and are at times exceedingly severe. As a malignant growth often involves the sigmoid, the patient is apt to point to the left of the abdomen as being the region where the gases move; or if the cecum is the part affected, his attention is attracted to the right side of the abdomen. Associated with an increasing difficulty in getting rid of the flatulence is a progressive constipation necessitating the frequent administration of cathartics. There are many remissions from these symptoms so that in the interim the patient believes that he has quite recovered. At this time diarrhea may even be present. It is not long, however, before the symptoms recur with increased vigor. A point of great diagnostic importance is the gurgling in the intestine which remains confined to the same spot where the gases move. This is characteristic when fermentation in the bowels can be excluded.

Chemical and microscopical traces of blood are often present but this test is of value only when it is found upon examination that there is no bleeding from the rectum and that during the time the test is being made, the diet has been limited. The patient is generally asked whether the stool is ribbon-like or normal in size; if answered that it is normal in calibre, the conclusion is often arrived at that there can be no obstruction in the sigmoid. As the stools assume the contour of the lower bowel, ribbon-like feces are only present when this is involved; hence disease of the sigmoid can not be excluded if this sign is absent.

It is important not to confound the distension of an intestinal arterio-sclerosis with that of a chronic ileus but the following signs of a splanchnic arterio-sclerosis will practically eliminate this condition.

In visceral-sclerosis there are usually present general vascular changes. It is claimed,<sup>6</sup> however, that

occasionally vascular intestinal changes may exist without any involvement of the general arterial system, but I, myself, have never seen this. High blood pressure and an accentuated second aortic sound are always present. Another point is the fact that the distention generally occurs after eating and that it is not associated with exaggerated peristaltic movements. A therapeutic test for this condition is the administration of diuretin, which acts very effectively.<sup>7</sup>

I saw a condition of considerable interest recently in a patient who was suffering from a gangrenous zoster; very severe attacks of cramps associated with distention were present during the entire course of the disease. Flatus could only be expelled after the administration of numerous enemata. As a result the patient walked the floor with a distended abdomen nightly for a period of three weeks; this condition persisted through the entire course of the zoster, and the distention and pain only subsided with the disappearance of the disease. In this instance, it was exceedingly difficult to exclude an incipient ileus.

**Treatment.** In a patient who experiences difficulty in emptying the bowels and greater difficulty in passing flatus, together with gurgling and severe pain, and where the condition seems to be progressing instead of remaining at a standstill, I believe there is a definite indication to open the abdomen; for it is in these cases that life can be saved and cancer cured if the abdomen is opened at a sufficiently early period. The diagnosis should be made upon these symptoms alone, and no time lost waiting to determine the presence of a palpable tumor, cachexia, loss in weight or visible peristalsis; for when these symptoms have become sufficiently marked, in the majority of instances the patient is lost. To be sure an occasional error in diagnosis will be committed but I have yet to regret opening an abdomen when an operation has been performed to relieve a condition of this nature.

From the foregoing remarks it is seen that the successful outcome in the treatment of bowel obstruction will depend to a great extent upon early diagnosis; hence *this* must be considered as the most important factor. In an ileus of unknown etiology where no localization has been possible, the abdomen should be opened in the median line by an incision extending from the pubes to the umbilicus. As growths most often involve either the sigmoid or cecum, the cecal region is quickly palpated and if this is found uninvolved, the hand is passed over to the sigmoid. In the majority of cases, the offending process will be found in either the one or the other of these positions, but if it is not discovered then further search must be made. Evisceration is not advocated because of the great shock which results from this procedure.

At this time it is important to discuss the principles of treatment which have been more or less generally accepted by surgeons of experience. The question as to whether an enterostomy of a distended loop should be established without searching for the



obstruction, or whether the obstruction should be sought for, is one which is far from having been determined. The statistics of the Heidelberg Clinic, published by Hesse,<sup>8</sup> show that where a resection of the gut has been performed for a gangrenous hernia, the mortality has been 33 1-3 per cent, and when an enterostomy has been established that the death rate has been 87½ per cent. Hesse's concluding remarks are: "That there is but one rational treatment for gangrenous hernia, and that is extensive primary resection of the necrotic gut, while the making of an artificial anus no longer comes into consideration as a life-saving procedure." As gangrenous hernia is operated upon earlier than most forms of ileus, it is evident that the good results in resection are due to the absence of toxemia and that the high death rate shows what a grave operation the simple enterostomy really is when toxemia is present. Elsberg<sup>9</sup> reports his experience in a number of cases of acute intestinal obstruction in which he advocates the operation of enterostomy performed by opening a loop of a distended coil of the intestine. He does not make a prolonged search for the obstruction and after the acute symptoms have subsided he performs a secondary operation for the purpose of discovering the cause of the ileus. His results are excellent and his methods seem to me to be worthy of consideration.

Monks,<sup>10</sup> in a recent article, advocates opening the intestine high up and lower down in a distended coil, which is then emptied and afterwards irrigated with saline through these openings. This same procedure is followed in various loops of the distended intestine. Monks reported one case where the patient seemed to be dying of a general peritonitis, and was apparently restored to health by the application of his method. This operation is much graver than a simple enterostomy and does not appeal to me because of the danger of shock and the possibility of soiling the peritoneal cavity. This is an accident not easily avoided, despite the statement of authors that the operation is comparatively simple. If the obstruction is due to a kink, band, or adhesion, it is not sufficient to relieve the constriction, for the poisonous substances contained within the bowel produce death unless gotten rid of. For example, in a strangulated hernia, where the constriction has been relieved, the patient dies despite the fact that the obstruction has been removed. Hence some attempt must be made to empty the intestine. Moynihan<sup>11</sup> advocates the introduction of a long glass tube into the distended bowel, which oftentimes can be pushed over the tube for a distance of eight or ten feet; in this manner a considerable quantity of fluid and gas can be evacuated from the intestine.

The impression prevails that when a bowel is distended with gas and is full of fluid, all that it is necessary to do is to puncture the gut and the gas will escape, allowing the intestinal wall to collapse. As a matter of fact, in an advanced stage of bowel obstruction, long before the patient becomes moribund, when the abdomen is opened, the intestinal wall is so thin and the muscle so paralyzed, that no gas whatever escapes when the gut is punctured. The only way the intestine can be

emptied of its contents is by milking or stripping the same after it has been opened, but as has been stated before, these methods do not produce any better results than were obtained a number of years ago.

I desire, in conclusion, to state my position in the treatment of acute intestinal obstruction, based upon an experience with a large number of cases treated by the various methods in use; I would emphasize the fact that the cases which I have treated with the most success are those which I have operated upon early and where I have not hesitated to explore the abdomen after the diagnosis had been established. My plan is similar to that advocated by Elsberg,<sup>12</sup> namely, if the obstruction is easily and quickly found, all that is done is to open the distended loop and to express the intestinal contents and to perform an enterostomy. This can be done in the following manner and in my opinion is the most important act in the operation. Two sharp hemostats grasp a spot on a loop of distended intestine, the beaks being in juxtaposition. The intestine is then opened by a knife puncture between the two points; the loop of intestine, having been drawn out of the abdominal cavity, is held close to a basin so that the fluid can escape from the gut without any soiling of the abdominal cavity. As clamps are attached to the loop of gut, there is no possibility of the intestine escaping back into the abdominal cavity, and the opening, therefore, is under absolute control. This opening may be closed with a purse-string suture or an enterostomy can be made. I have treated a number of cases seen early, in this manner with fairly satisfactory results. It is my intention to continue this method in the future, as it is rational, simple and easily carried out and without much shock to the patient. After the acute symptoms have subsided the abdomen can readily be opened a second time and the cause of the obstruction determined; this can then be remedied without undue haste.

Regarding the employment of drugs, such as atropin and eserine for bowel obstruction, I would state that these remedies have been of no avail in my experience.

The treatment of chronic bowel obstruction is one that requires separate consideration.

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#### SOME REMINISCENCES OF INDIAN PRACTICE.

By FORDYCE GRINNELL, M. D., Pasadena.

Many diseases of civilized life were not familiar to people whose time was spent mainly in the open air.

The early adventurers among the American Indians assert that tuberculosis was unknown in their native wilds. When gathered on reservations and

rude huts were built for them, poorly ventilated, and their food was changed from venison and buffalo and wild berries and teepsons,—to bacon and poor flour,—then the disease appeared. It has since proved their worst foe.

Filth diseases, the scourge of our cities, were seldom seen. The habit of living in tepees and moving from place to place in following their game, did not permit the accumulation of filth. As a rule these people were cleanly in their habits, resorting often to the bath, or the sweat-house.

It is doubtful if in their native haunts diphtheria or typhoid fever were ever known. I never saw a case among those allowed to live after their own fashion in well ventilated tepees, with location often changed. On the other hand malarial diseases, along the water courses were quite common. But whether these aborigines had discovered that the mosquito was the producing cause, I do not know; but I do know that when, at the reservation situated on the creek bottom, they began, in the autumn of the year, to be seriously affected, they requested permission to go on a hunt to the arid uplands and mesas, when the malarial symptoms disappeared and they returned in due time fat and flourishing.

Pleurisies and pneumonias were not unknown, while catarrhal conjunctivitis as well as the granular form were frequently seen. The smoky lodges undoubtedly contributed to these diseases of the eye, as among the older men and women pterygium was frequently noted.

Venereal diseases, I think were wholly unknown until the advent of the military forces upon the frontiers in proximity to the people. Then among some tribes these ailments became very prevalent.

The Indians have no record of epidemic diseases such as smallpox, until introduced at an early day by explorers,—but when introduced, smallpox spread with wonderful rapidity and resulted in great loss of life.

The sweat-house, used by the medicine men as a valuable adjunct in the treatment of many diseases, here wholly failed, for putting a patient in a hot steam bath for a time and then subjecting him to a cold plunge, was not conducive to recovery in smallpox, and many died from the treatment. While incantations and various feats of jugglery were used by the medicine men to drive away evil spirits afflicting the sick, yet many useful means were also adopted and much skill was often used by these rude people of the plains.

In case of fracture, splints were applied, frequently in a very skillful and effectual manner. In severe internal pains, the buffalo horn was used as a cupping instrument, and in lieu of the horn the mouth was sometimes applied and powerful suction produced. I once saw a medicine man thus treat an Indian who was writhing in pain. After repeated suction over the place, he spit forth a grub and exhibited it as an evidence of his skill, and the cause of the pain. The offender was removed! The patient was relieved! The medicine man was triumphant! Who says Christian Science so-called, or faith healing, is a new thing under the sun? The

Indians of the plains applied its principles long before Mrs. Eddy began her incantations.

Concoctions of roots and herbs were not infrequently used as remedies in the treatment of the sick, and sometimes no doubt with benefit. Certain roots and leaves mascerated and placed upon ulcers or abrasions were a common method of treatment of these conditions, and so of wounds. A Caddoe medicine man once sent for me in consultation. He said a youth of one of his people had been seriously injured by an arrow. The boy by a careless maneuver of a companion had been shot through the chest walls, the lung punctured, and in withdrawing the arrowhead a portion of the lung had come with it. With every inhalation, this part of the lung was inflated as it still held by considerable attachment. The medicine man suggested that if I would correct this difficulty, he would apply roots and herbs and thus effect a cure. In those days in order to obtain the good will of the people, it was necessary to concede something to their ideas and customs and possibly divide honors with them in case the results warranted. I proceeded to ligate the portion of the lung protruding through the chest walls and return the stump within the thoracic cavity, after applying carbolized oil. The medicine man applied his poultice and in due time a good recovery resulted. The portion of lung removed was about two inches wide by three in length. Considering the time elapsing since the receipt of the injury, about twelve hours, we thought the results satisfactory.

Some of the medicine men erected for themselves large and commodious medicine houses, and decorated them with symbolic paintings and surrounded all their proceedings with great mystery so as to inspire respect and a certain awe among their people. No one could enter the enclosure without removing the shoes, and it would be considered a great breach of propriety to pass between the patient and the fire, which was burning in the center of the lodge. Although stating that I had methods quite as essential which must be put in practice in order that the patient might recover, yet in an early day when prejudice existed as to other methods than their own, I have so far conformed to their customs as to put my shoes off my feet in entering the medicine lodge, just as one must do on entering the Mosque with a brother Mohammedan. Thus gaining their good will, I have been able to use remedies suitable for the conditions, and have gained a brother as well as a patient.

These people were not long in recognizing the superiority of civilized methods. One of my first surgical cases was that of a Comanche brave, who while at a beef issue, received a gunshot wound. On the occasion of these beef issues a great number of Indians are present, from some hundreds to one or two thousand, and the heads of each family pursue their allotted cattle much after the manner of the buffalo hunt. The shooting in all directions renders the occurrence of accidents quite probable. An examination in this case exhibited a wound over the left eye, and indicated that the ball upon strik-

ing the superciliary ridge of the frontal bone, had glanced downward and entered the cavity of the eye. Dividing the outer commissure of the lid, under chloroform, I removed the bullet lodged in the eyesocket, together with the disorganized eyeball. No injury making up the orbital cavity was discovered. The patient made a good recovery and offered his medical man the best of his ponies, and ever after on meeting him, insisted on enfolding him in his arms to express his gratitude. The wonder of this people was the power of that agent, a few inhalations of which gave the patient a quiet sleep during the operation.

As a rule child-birth was attended with less difficulty among the women of these people than in civilized life, the pelvic bones being broad and well developed. There was no displacement of organs from corseting, no lack of exercise to harden and develop the muscles, no lack of fresh air to vitalize, no poodle dog to hug and kiss. Like the Hebrew women in the land of Egypt, "They were delivered ere the midwives came to them." It was not an unheard of occurrence that when these people were on a journey a woman whose full time had come, would step aside and be delivered, and after a few hours' delay rejoin her people in their onward march. The position assumed in child-birth among some of these people was upon the knees, leaning upon a pallet or couch. A case which I reported from Wichita Indian Agency, Indian Territory, in 1878, to the *Obstetrical Gazette* was as follows: "Was called yesterday to an obstetrical case occurring in the Pawnee Camp. The child had just been born. A large tumor remained and the husband suggested twins. On examination found uterus quite distended. There appearing want of uterine action I gave quinin and ergot, and awaited establishment of suitable contractions. The woman was lying on her back, on a pallet elevated at an angle of 45 degrees, with knees raised and feet resting on the ground in a half-sitting, half-reclining posture. When she began to feel the contractions, she turned over on the couch, resting her knees and elbows at the angle named. I noticed her making adjustments, which I did not fully comprehend and making an examination when the pain came on, I discovered there were two cords, and forcible traction was being made upon each of them. Following these cords to their termination, I found them attached to two flattened stones about the size of bricks. Around these were tied pieces of cloth, and to each stone was attached the end of a cord. Upon the occurrence of each contraction these stones were so placed against the knees of the woman that she could with slight elevation of her body draw upon the cords with as much or as little force as she desired. The novelty and ingenuity of this method of making traction upon the cord, forcibly impressed me with the ready wit of the Indian in adapting means to ends for each emergency. The woman here became her own accoucheur, and the amount of traction was always proportionate to the felt needs of the operator. But in this case her tactics did not succeed, for it was noted that as she pressed upon

the cords the blood would flow quite freely. An examination disclosed adhesions, which being detached there was removed two separate and distinct placentas, each as large and complete as an average one, and with a cord inserted in the center of each. But one child was born, yet here appeared the accompaniments of two. The two cords appeared to unite near the umbilicus, some 23 or 24 inches from the placental insertion. As in a similar case published by Cazeaux (5 American Edition) occurring in the practice of Dr. Erbert, the membranes furnished a single cavity, and constituted the connecting link between the two placentas, these forming a kind of membranous bridge. The extreme rarity of like recorded cases rendered this one of much interest. While studying upon this anomaly, the attendant squaws came in, and taking up the placentas, membranes, soiled clothes, and even scraping the earth where blood had fallen upon it, wrapped all in a tightly corded package and carried away for burial. Other women came in with fresh earth and covered the floor where the couch had been. Others brought in armfuls of freshly-gathered herbs and placed them upon the earth. Upon these the robes and blankets were spread and the woman was comfortably disposed, making a good recovery.

In this connection I may say that to most American Indians the menstrual period is one of uncleanness. All secretions as above noted are carefully removed, and the woman is usually relegated to a separate tepee during the entire period. With them the rituals of the ancient law seem to prevail, "Everything that she lieth upon in her separation shall be unclean. Seven days shall be set apart."

An interesting abnormality has been noted from time to time of infants born with one or more teeth, usually the two lower incisors. A case of this kind came under my care, of a halfbreed child. The mother called my attention to the fact that the child could nurse only with great difficulty. I found that the under surface of the tongue was ulcerated and inflamed from abrasions produced by passing over the lower incisor in the act of nursing. This was the earliest case wherein I was called upon to extract a tooth. The child was now about a week old and was born with this tooth well projected. I have since noted that heredity plays an important part in the frequency of the production of this abnormality. Thus the Johnson family of Kentucky records for several generations children born with well developed lower incisors.

It is not so long since that our own race has advanced from the period of burning witches and exorcising evil spirits, nor so far back in antiquity that our barbers practiced phlebotomy, that they do not still exhibit the red and white striped pole as a sign of their calling, and their ability to bleed.

It is said that the tendency of the human race is to move in cycles, that one generation forgets the achievements of a former and calls the resurrection of things and ideas known of old, new inventions. In recent excavations the finding of surgical instruments very like some of those of late construction, leads us to conclude that a people who knew the



art of embalming their dead, also knew many other things which later generations mayhap have since rediscovered. When we contemplate the state of advancement to which this culture has arrived after so many ages of endeavor, we can only wonder that the aborigines attained to so much that was practical.

### VACCINES.

By ROBERT PATEK, M. D., San Francisco.

For a just estimation of vaccine therapy as proposed in recent years by Wright, two points of view must be taken; first, the biological, second, the clinical. I will take these up in turn. Now the role played by the circulatory fluids, the plasma, and the cells in natural and acquired resistance has been a problem of much experimentation. It will serve our purpose to begin with the work of Denys<sup>1</sup> and Leclef in 1895. They produced reliable experimental evidence that the serum of rabbits vaccinated with streptococci contained substances which acted on this microbe and rendered it phagocytizable. This substance was present in normal serum in comparatively small amount. The immunized animal fights the bacteria, first, by the direct action of its serum, second, by the leukocytes. The latter always owe to the serum the commencement of their power.

These conclusions are clear from the following experiments:

(1) Leukocytes from a normal rabbit added to normal rabbit serum exhibit only a feeble phagocytic power to streptococcus. Also the leukocytes die prematurely.

(2) Leukocytes from a normal rabbit added to serum of a vaccinated rabbit energetically destroy streptococcus. The leukocytes preserve their normal duration of life.

(3) Leukocytes from a vaccinated rabbit added to normal serum show same as (1).

(4) If a dose of streptococci capable of producing erysipelas is introduced under the skin of a vaccinated rabbit the infection is prevented especially by the leukocytes.

Now this substance (group) which renders micro-organism ingestible by the leukocytes was called by Wright and Douglas<sup>2</sup> in 1903 "opsonin" (opsono Lat., I prepare the food for). They were working with normal serum and found,

(a) Staphylococcus emulsion plus washed leukocytes plus Na Cl solution at 37° C for 15 minutes equals no phagocytosis. When serum is added, active phagocytosis begins.

(b) Three volumes washed corpuscles plus three volumes serum at 37° C for 15 minutes, then heated to 60° C (destroying the thermolabile opsonin) cool plus one volume emulsion of staphylococcus at 37° C for 15 minutes. Result is little or no phagocytosis.

(c) Three volumes serum plus one volume emulsion staphylococci at 37° C for 15 minutes. Heat 60°. Then add three volumes corpuscles 15 min, 37°, result is marked phagocytosis. Hence, action of serum is mainly to modify the bacteria in such a way as to render them a prey to phagocytosis. Simultaneously and independently this work was done by Neufeld and Rimpau.<sup>3</sup>

Now, Leishman<sup>4</sup> had, in 1902, devised a method for quantitatively estimating phagocytosis and called same the "phagocytic index." Wright modifying this method, brought forth the opsonic index. The opsonic index is determined as follows: equal volumes of (1) a bacterial emulsion in N Na Cl. and (2) Washed leukocytes, and serum to be tested are, after thorough mixture, incubated for 15 minutes at 37°. A drop of this is spread and stained. The enumeration of bacteria in 50 polymorphonuclear—neutrophils is made under oil immersion and the average per leukocyte obtained. The ratio of this average to that for a normal serum using the same emulsion and corpuscles, constitutes the opsonic index.

Simon<sup>5</sup> has modified this method by determining the percentage of polymorphonuclear neutrophils that phagocyte disregarding entirely the number of bacteria ingested. His results parallel those of Wright, and as regards accuracy and ease of counting, this technic is obviously a distinct advance.

As the term vaccine will from now on be frequently used it becomes necessary to define the term. Vaccines, as used for therapeutic purposes are emulsions of dead bacteria. There are two kinds, (1) autogenous, that is those prepared directly from the patient; (2) those prepared from stock cultures; these latter are called heterogeneous.

The preparation of an autogenous vaccine is as follows: let the case be one of furunculosis. The expressed pus is obtained as free from contamination as possible. Agar plates are inoculated, streaks being sufficiently diluted to obtain isolated colonies. The plates are incubated eighteen hours. The cultures are as a rule pure. From a single colony a transfer is made to slant agar and incubated eighteen hours. The growth is now scraped off and decanted into a test tube. The organisms are emulsified by hand shaking for ten minutes. Then equal amounts of the suspension and blood are thoroughly mixed in a blood counter, a smear of mixture made and stained, 500 reds are counted and the number of organisms encountered during this operation noted. This obviously gives the number of bacteria in a c mm. of our suspension. The remainder of our suspension is killed at 60°, 60 minutes, and diluted as desired. One-fourth per cent lysol is usually added to insure absolute sterility. This then is our standardized autogenous vaccine.

Returning now to opsonins let us first consider the accuracy of the index. That phagocytosis faithfully follows definite laws seems probable. That opsonin plays a part in phagocytosis is certain. That other factors influence phagocytosis is also certain. Whether these can be sufficiently controlled to render the opsonic index exact may be open to question.

Moss<sup>6</sup>, 1907, working with this in mind, used a homogeneous emulsion of fresh leukocytes, well washed. This was well mixed with a homogeneous emulsion bacteria (staphylococcus aureus). Smears counted showed in twelve different portions of the slide, 50 cells to each section, the extremes to be 267 to 503, average for 600 cells equal 406. It is evident that 50 cells is too small a number; also that the counts made near the end of smears are

slightly larger than those at beginning. Assuming 406 to be correct, the error of the two extremes is 25 per cent.

Sellards<sup>7</sup> worked with the tubercle bacillus. He also noted the zonal distribution on the slide of the leukocytes, thus confirming Moss. Working with the same normal serum he got results ranging .4 to 2.34 for the tubercle bacillus. And in a case of tubercular peritonitis his results taken at one time range from 0.71 to 2.07. These results were obtained in the counting of 50 cells. His conclusion was that probably large differences in indices mean differences in opsonic content but at present we cannot feel that moderate differences mean anything. To count enough cells and to make enough controls to assure accuracy places the method outside of clinical application. Some of the factors which produce this inaccuracy are as follows: Strength of the bacterial emulsion used. Knorr showed that the stronger the emulsion the higher the opsonic index. Again, the opsonic index varies with the time and  $T^{\circ}$  of incubation. Another unexplained variation of the opsonic index was found by Moss in diluting his sera, thus he frequently had his lowest index in the undiluted serum; the highest in 1/50 to 1/100 dilution. Thus undiluted gave him .37, 1/50 gave 1.49.

The opsonic index for an organism will depend largely on its virulence. The serum may contain a good amount of specific opsonin without giving evidence of same. In virulent organisms a specific substance is present; this can be washed out with salt solution and the organism is now easily phagocytized. This substance can now be brought into contact with nonvirulent (i. e. phagocytizable) bacteria of same species. These now show a definite resistance to phagocytosis. This virulin is thermostable, resisting boiling. It is specific for the bacterial species from which derived. That it does not injure the leukocytes very markedly is shown by the fact that bacteria of other species are ingested in its presence.

*Age.* The opsonic power of blood disappears gradually on standing. In 5 to 6 days it is about  $\frac{1}{2}$  as much as the original. A temperature of  $37^{\circ}$  destroys opsonic power in about three days.

Hort<sup>8</sup>, in the *British Medical Journal*, to test the practical reliability of the determination, sent two or more samples of serum, obtained under precisely similar conditions to two or more workers. He also sent two identical serums to same workers. The number of cases 12; the men employed had established reputations.

The results are disappointing,—thus:

Case 1	Observer A.....	1.34
	Observer T.....	.67
	Observer T.....	.55
Case 2	Observer A.....	1.06
	Observer B.....	.98
	Observer T.....	.82
Case 5	Observer B.....	.88
	Observer T.....	1.17
	Observer T.....	1.34
	Observer A.....	2.34

Just one word more in regard to the opsonic index. We have seen that it is quite inaccurate. Moss found that in normal animals, its variations showed excursions equal to those found in animals undergoing vaccination. This is of prime importance because even if the index were correct, the variations could not guide us clinically in vaccine administration. Wright recommends the giving of the vaccine when the index is low, and assumes that the rise following is one of cause and effect. That such a conclusion is unwarranted the following makes clear.

The indices of four rabbits G. H. I. J. before any vaccination ranged from

G. ....	.81	.....	1.34
H. ....	.87	.....	1.57
I. ....	.70	.....	1.26
J. ....	.14	.....	.59

During the same period the variations of two normal sera (human) as compared to a 3rd, the latter being the standard used for the rabbits, was .70 to 1.66 and .84 to 1.95.

After these preliminary observations, all of the rabbits were inoculated subcutaneously with aureus. The indices now taken, varied in an apparently lawless way and no deductions could be drawn from them. The whole thing may be summed up by stating that if these results are trustworthy it would not seem possible to make use of the opsonic index as a means of diagnosis or as an indication for treatment by vaccine.

*Specificity.* As to the specificity of opsonin, I will inform you at the outset, that in normal serum we have common opsonin so-called, while in the serum of vaccinated animals we have added to this a specific opsonin.

Klein<sup>9</sup> worked with typhoid bacillus. It is of interest to note that he found great difficulty in estimating the index, because the typhoid bacillus was so quickly digested after being taken up by the leukocyte. He injected living organisms into rabbits and compared the serum of such animals with normal.

The immune serum on heating  $55^{\circ}$  to  $58^{\circ}$  for  $\frac{1}{2}$  hour showed no loss in opsonic power for typhoid. On the contrary the opsonin of normal serum was thermolabile.

Dilution	Immune Serum		Heated		Unheated	
			Opsonic Index		Opsonic Index	
1/192.....			2.87		2.32	
1/768.....			.638		.53	
Common Serum						
1/12.....			4.7		.2	
1/24.....			.65		.04	

To test this specificity further he tried to absorb the immune opsonin by saturation with other bacteria; the opsonic index for other bacteria was also determined not only with an unheated normal serum but also with a heated one.

Phag. Index	Typhoid Serum		Normal Serum	
	Heated	Unheated	Heated	Unheated
against aureau.....	7.5	6.3	6.7	.51
against strept.....	6.2	2.4	6.7	1.8
against Tb.....	1.9	.2	1.9	.29

We see at once that the immune serum had no higher opsonic power for other organisms tested than had normal serum, and heat removed the same amount of opsonin in both sera. Therefore the

typhoid immune opsonin is specific; at least against the organisms studied.

And now a final word of comparison between opsonins and certain of the other substances important in immunity.

1st. Relation to complement: We have seen that in the heated sera the opsonic (specific) power was retained. Thus it is evident that the opsonin acts without the intervention of complement as complement is completely destroyed at the temperature used. The complement may also be removed by saturation without impairing opsonization.

Like the complement and the toxin the opsonin has a haptophore and opsinophore group. The haptophore group can be bound by various salt solutions, as Ca. Ba., etc.

2nd, Relation to amboceptor: It is sufficient to note that the amboceptor requires the intervention of complement in order to act and thus differs in an essential character from the opsonin.

3rd, Relation to leukocytosis:

A second important difference between amboceptor and opsonin is brought out by Moss in his vaccinated rabbits; the opsonic content of their serum was only slightly raised and then not long sustained, while the amboceptor could be increased almost indefinitely by repeated vaccination.

In their research on the therapeutic effect of yeast in tuberculosis, Huggard and Nurland<sup>10</sup> found that after a preliminary rise the leukocytes remained constantly below normal. As the opsonic index was at first low and later high, it was apparent that there was no relationship between the two. The same results were obtained by Bullock and Ledinghaus.

Source of opsonin: All authors agree that the opsonin exists in the blood and not in the leukocytes. The absence of any relationship between opsonin and leukocytosis might be regarded as some evidence against Metchnikoff's belief that the leukocytes furnish the opsonin to the serum.

Clinical. Wright<sup>11</sup> published a report of his first cases in the *Lancet*, 1902, and it is of sufficient historical importance to quote a few lines from the same. Haffkine had observed that patients given antiplague vaccines (injections of dead cultures) during the incubation period, ran a milder and briefer course than the unvaccinated. Wright having this fact in mind wrote as follows:

"If it holds true that vaccines have a therapeutic value in the incipient stages of bacterial invasions which may afterwards assume a septicemic form it must, *a fortiori*, hold true that inoculations conducted with bacterial vaccines may render useful service in bacterial invasions which manifest themselves from first to last in the form of localized inflammatory processes."

He put this to the test in six cases of aureus infections, selecting them because of their chronicity and because of the failure of other methods. The cases grouped themselves as follows: furunculosis, syccosis, infection of finger with secondary bubo in arm and boils.

While we view with some doubt, his opsonic find-

ings, the impressive fact is that five of his cases made complete and fairly rapid recoveries. The sixth improved but was never cured.

He used autogenous vaccines. He noted that aureus could be substituted for albus and vice versa, and this has been confirmed; but the best results are always obtained in this group of cases with autogenous vaccines.

I have used autogenous vaccines in two cases of acne, in one without result, Dr. Grosse finally resorting to the X-Ray and obtaining a complete cure. A second case, in a boy, improved but recurred.

Doses. The doses for aureus and albus should start in an adult at 250 M. and increase to 1000 M. or even 2000 M.; the interval should be 7 to 10 days between doses; the number of doses depends on the progress noted.

Age of Vaccines. In a case of chronic boils, due to aureus, the result was really most striking; the patient, a doctor, had had boils on the back of the neck. He received one dose 250 M. near site of lesion. Considerable pain present during the first twenty-four hours. The indurated area, softened, healed and there was no recurrence in six months.

Dr. Ryfkogel used this vaccine in a second patient; result, cure.

It will be well to remind you that vaccines are potent for about two months only.

Cole and Meakins<sup>12</sup> report the results in fifteen cases of gonorrheal arthritis treated with vaccines. They found no difference in effect when patient was treated with homologous or heterogenous vaccine. Their doses ranged from 240 M. to 1000 M., the number of doses given ranged from one to eight. The interval between doses seven to ten days. The injections are given subcutaneously; the regions selected are usually either interscapular, gluteal or anterior surface of thigh. Wright advised that the vaccine be injected near the point of infection (if local) as this caused a flow of bacteriotropic or opsonic substances toward a point of lowered bacteriotropic pressure. This, by the way, is what Bier's hyperemia accomplishes, namely a continued washing of the part with more lymph than would ordinarily come to it. And this, too, is why abscesses should be punctured. The fluid of abscesses contains little or no opsonin. Removing the pus by puncture and bathing the part by Bier cup with new lymph, gives when combined with vaccine the ideal treatment in light of our present knowledge. This, too, has been used to explain the good results following simple exposure and removal of the fluid in tubercular peritonitis.

Coming back to Cole's gonorrheal cases; these cases all recovered without impairment of function. Some of the cases had resisted all other forms of treatment and changed for the better at once under vaccination. That the vaccine in this group of cases played an active role in bringing about cure is undoubted.

Several points of interest arose in the cases. Case 1—Apparently cured of his gonorrheal arthritis, returned six weeks later to the hospital. Patient died of lobar pneumonia. His elbow was for all clinical



purposes well, yet at autopsy a pure culture of gonococcus was obtained from the elbow. The joint itself showed signs of a recent acute inflammation.

These good results have been obtained by other observers. Hartwell reported 31 cases, all with good functional results.

Vaccines in Acute and Chronic Urethritis. The use of the vaccines (specific) in acute urethritis is said to shorten the process. In chronic cases, where the gonococcus is present with secondary invaders, the vaccine will remove the gonococci from the urethra but between the damaged mucous membrane and the secondary invaders, the catarrh continues. Dr. Grosse has a case illustrating this clearly. The patient's flora was plated out, and Dr. Ryfkogel and myself made homologous vaccines for him. Now plating again we found our first organisms gone and others taking their place, in other words, we had by vaccination removed certain saprophytes, thereby giving others the upper hand, the discharge showing little or no change. It is therefore clear that little can be expected from vaccines in the type of case described, unless the gonococcus is present.

Loxton<sup>13</sup>, reports 3 cases in which he removed the gonococcus from the urethra by vaccination.

As regards vaccine treatment in gonorrheal vulvovaginitis in children, Butler and Long<sup>14</sup>, reporting an epidemic of 12 cases, state, "Vaccine therapy has a place in the treatment of gonorrhea and appears more efficient than local antiseptics."

Dr. Grosse has a patient with an enlarged prostate; he has a colon cystitis. The homologous vaccine dose 100 M., 7-day intervals cleared his urine markedly. From a large amount of pus to a mere trace; odor became inoffensive, and subjectively the patient was much improved, especially as regards frequency. But the urine always contains living colon; and this absence of bactericidal action has also been noted by Gerahty<sup>15</sup> in an experience with five cases of bacteriuria.

Tuberculosis. The question of vaccines in this condition involves the whole subject of tuberculosis therapy. I will make no effort at this, but merely draw your attention to a few fundamental facts. Tuberculosis must be divided into local and general. The local includes such conditions as tuberculosis of glands, bone, skin, etc. In this group of cases, vaccines have been very successfully employed. They must, however, always be combined with the usual hygienic methods. The question of dosage and frequency is most important, but the doses should vary approximately, ranging from 1/1000 .0025 mgs. and the interval 7 to 10 days is the experience of most clinicians.

Wright states that the bad effects seen in over-dosage are due to the negative phase. By the negative phase is understood a condition of lowered opsonic content. The mechanism theoretically bringing it about is as follows: The vaccine sets up at the site of the tuberculosis lesion a local reaction. If this be too marked the system is flooded with toxins, debris, etc., and the opsonin used up too rapidly, hence the lowered opsonic content. With small doses this negative phase may be almost com-

pletely suppressed. Be this explanation correct or not the clinical picture of over-dosage is constant and striking. The type of organisms whether bovine or human is also very important.

In pulmonary tuberculosis and in the sinuses, the factor of secondary invaders plays a part; just how great remains yet to be worked out. But the value of tuberculin in this condition is vouched for by many men of wide experience.

Cerebro Spinal Meningitis. We have noted that opsonin is too variable to be depended upon for diagnostic purposes. As regards this disease, an exception to this statement must be made. Rankin and Houston<sup>16</sup> report their experience with 63 cases (*Lancet*, 1907). They found phagocytosis so marked with the serum of affected individuals that it was impossible to count the bacteria in the crowded leukocytes. And this was in great contrast to normal serum and in their mind was of the greatest diagnostic value. These results were obtained at the 6th day, with one exception, where it occurred on the 7th.

They bring out a rather important point in regard to serums of the Flexner type. They found in many of these no opsonin or agglutination. From such a serum little can be expected. Age probably accounted for the loss of potency.

Empyema. (a) Gallbladder. Wright and Reid<sup>17</sup> prepared homologous vaccines in two cases of cholecystitis with persistent sinus. Sinus healed under vaccine treatment.

(b) In thoracic empyema, with persistent discharge, closing of the sinus with permanent healing has been obtained with homologous vaccines.

Erysipelas. Shorer<sup>18</sup>, in Bellevue, reports 37 cases, vaccines from 4 strains being used. He thought the disease was somewhat shortened, but found the vaccines did not prevent recurrence or emigration.

Pyrrhea Alveolaris. Hitherto an incurable disease, seems capable of cure in a considerable percentage of cases. While many organisms are obtained on planting, the streptococcus and the staphylococcus seem to be the organisms of importance. They can be frequently obtained from the patient's blood. In 5 cases reported in the *Lancet*<sup>19</sup> all showed definite reactions to the homologous vaccine.

At present Doctor Adolph Baer has a case of pyrrhea alveolaris under treatment. At the time when first seen all the teeth were loose, six being so freely movable that extraction seemed the only thing to do. Pus could be freely expressed from the sockets of all the teeth. The pus on plating showed among other organisms the streptococcus. A vaccine was prepared from this. The first dose approximately 20 m. injected subcutaneously in the scapular region, gave both a local reaction, manifested by marked pain in the jaws, and a general reaction, indicated by general malaise. This reaction was brief. The patient has received two further doses at weekly intervals, without reaction. The usual hygienic medication of the teeth has also been employed. Result: pus can only be expressed

from one tooth. The teeth are now quite firm with the exception of one tooth which may be lost. The patient can now firmly close the jaws, though this was impossible previously because of the pain. His general condition is improved. Whether or not he will go on to complete permanent recovery remains to be seen.

Malignant Endocarditis. Bullock has reported with great detail one case of malignant endocarditis seen in consultation with Sir Wm. Barr. The patient recovered with a homologous vaccine obtained from culture of own blood. The organism was the streptococcus.

Rosenow<sup>21</sup> was less fortunate, he lost twelve cases in the same way, no recoveries. The pneumococcus was the invading organism in most of his cases.

A word in closing. That vaccines have a therapeutic value, in certain cases, you will, I think, all agree. It is to Wright reporting his first cases in 1902 that the credit for this addition to our rational therapeutics is to be given, but it is a strange trick of time that Hahnemann, writing decades before, laid down as his chief tenets the minimal dose and similia similibus curantur.

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#### A CLINICAL LECTURE ON WEAK-FOOT.\*

By JAMES T. WATKINS, M. D., San Francisco.

To show how common have become acquired distortions of the foot, especially those associated with the several manifestations of weak-foot, it may interest you to hear that of nearly 800 young men lately examined by me as candidates for positions on the police force almost all showed some foot deformity and more than 30% of them were rejected for defective feet alone. The causes for this almost universally present distortion must be sought in the conditions which obtain at early age. The worst shoes to be obtained in the market are those worn by children. I have never seen a good child's shoe. The flexible feet of growing children are maintained by vicious shoeing in abducted, cramped positions while their component bones mutually grind improper facets upon each other. This fact explains the observation of Blodget that of 1,000 cases of painful weak-foot treated in Boston, while the objective symptoms disappeared in nearly all cases, an anatomical cure practically never occurred. The

\* Given at the Polyclinic Gathering.

static error consequent upon mutually distorted bones obtained to the end of the chapter. Again, it is to be remembered that many flat feet present no subjective symptoms while conversely feet with particularly high arches may be excruciatingly painful. Further, Osgood has shown that while in the normal foot the strength of the adductor supinator group is to the strength of the abductor pronator group approximately as 10 to 8, in the pronated or weak-foot the strength of the first group is to the second approximately as 9 to 10. The foregoing observations, taken together with the facts that some of you have sent me patients who had worn for years plates given them by experts and yet who had got gradually worse, patients who have since recovered from their subjective symptoms without plates (you being the witnesses thereto) have led me to the following conclusions:

1. In the great majority of flexible weak feet the cause of the condition should be sought in a disturbed muscular equilibrium.
2. Children and young persons with flexible feet, or feet which can be made flexible, should never be given plates, but should have their shoes so modified as to enable them to assume that position in which the muscles work at the best advantage and in which there is the least ligamentous strain.
3. That in the great majority of cases there exists a constitutional predisposing cause calling for the attention of the regular family physician.
4. That where feet are permanently misshapen or only partially flexible one or other form of plate may be needed.

5. That to follow any kind of routine treatment is unscientific and prejudicial to the best interests of the patient.

Turning now to our patient, you will observe he is of the overgrown, long-limbed, loose-joined, rickety type. This is the sort of a person in whom you see the genu valgum staticum of Schede and the Italians, and the late appearing coxa vara of Albert. Examining his feet we note their circulatory disturbance, as shown by congestion and sweating; the muscular changes, as shown by the fibrillary twitchings, the uncertain voluntary motion, and should we measure it, the changed relations between the relative strengths of the adductor and abductor groups; note, too, the too great flexibility, as shown on passive motion.

Ideally this boy should be taken off his feet and put to bed. His general asthenic condition should be looked to. His muscular control should be brought to the maximum efficiency by graduated resistance exercises, best accomplished by the use of the Baumgartel or Zander machines, and vigorous massage. Hot and cold douchings and the hot-air oven would play their part. Gradually he would be got upon his feet wearing the shoes I am going to show you. He should be instructed in proper walking positions and recommended to wear broad inelastic stockings and if possible to walk barefooted in the loose sand daily. At not time should he render his feet unduly tired.

An examination of the deficiencies of such a foot reveals the need for the corrective features which should be embodied in an appropriate shoe. The foot is abducted—the poison of muscular rest—therefore the shoe should assist it to assume the position of adduction, the attitude of muscular activity. This is accomplished by introducing into a straight last shoe an insole of leather, which will exert a thrust up-

ward and especially outward upon the scaphoid and astragalus. By thrusting the foot over against the outer side of the shoe this makes room for the front of the foot to adduct during muscular action and prevents rotation downward and inward of the astragalus on the calcis. In this way the former is prevented from slipping off the back of the latter. Most of the trouble occurs in the calcaneo-astragaloid point. To further counteract the tendency of the calcaneus to roll over on its inner side, and to diminish the strain upon the inferior calcaneo-scaphoid ligament, we raise the whole of the inner side of the insole, raise the inner side of heel and of sole, and flange the heel inward. But the long shank of shop-made shoes was not constructed with a view to supporting the added weight thrown on it by this corrective insole. Left to itself the shank would sag downward and cause the insole to become inefficient. This defect is remedied by carrying the heel forward one inch under the inner side of the shank. In this way the weight is transmitted directly through insole and heel to the ground. Further than this the patient is encouraged to undertake adduction and clawing exercises and will later be taught rising on the toes in addition.

Because the majority of painful feet receive an appreciable measure of temporary relief from almost any form of instep supporter, incompetent persons, usually in the shoe trade, are tempted to prescribe for this condition. And for the same reasons the conscientious specialist is too often unable to obtain from the patient the faithful performance of those muscle building exercises which can alone bring about a complete and permanent removal of the disability.

#### Polyclinic Gathering.

The second case I wish to show is this little girl. She is eight years of age. We are told that ever since she was born she has shown evidences of paralysis of her right leg and arm. The child is an orphan, and no further history is obtainable. The condition of her arm is said to have greatly improved, as has, to a less degree, that of her leg. While clinically she presents the picture of an infantile paralysis, before attempting operative interference we will refer her for an opinion to our colleagues of the nerve clinic. So eminent an orthopedist as the late Professor Haffa operated three times upon cases which Oppenheim later showed to be of a nature where operation was contraindicated. The lesson to be derived from their controversy is that no doubtful borderline case should be brought to operation until it has been subjected to a careful examination by a competent neurologist.

Whatever her original lesion was, it would appear to have left this child with a drawn up heel—pes equinus. For this condition she was taken to a general surgeon who, we are told, operated to relieve it. Inspection now discovers a scar over the middle of the tendon of Achilles, and by manipulation we find, as you can readily perceive, a definite break in the continuity of the tendon. Either the tendon did not unite after tenotomy or the scar has subsequently stretched. To-day the child presents a hollow foot—talipes calcaneus, which is also valgus and which is reported to be getting gradually worse. Observe that as she uses the foot in walking the deformity is exaggerated. Now that the group of muscles inserted into the calcaneus is out of commission, the combined action of the muscles which pass under the sustentaculum tali and under the external malleolus is to cause the heel and forefoot to approach one another. Note further that Meyer's line,—a line drawn through the middle of the patella and the middle of the ankle joint, which when prolonged should pass through the fourth toe or the third interspace—now intersects the forefoot at the middle of the first metatarsal bone. That is, the foot is markedly pronated, and there is a tendency

for the astragalus to rotate downward and inward off the back of the calcis, taking the leg with it. This condition, which is at first an exaggeration of the physiological attitude of rest, is certain to become aggravated as she gets heavier. Further, changes in the soft parts will tend to make the distortion permanent. The patient presents then in its earlier stages the distortion which we recognize as talipes calcaneo-vulvus,—the most intractable deformity of the foot known to orthopedics.

Pending the report of the neurologist, if we assume the case to be one of infantile paralysis, and the remnant of muscular power left to be inadequate for the replacement of the sural group, there are three operative procedures open to us, Goldwait's operation, the procedure recommended by Royal Whitman, and the operation devised by Robert Jones of Liverpool. The object of all three operations is to correct the deformity and to maintain the foot in proper relation to the leg by obliterating all motion which cannot be controlled. I may interpolate that operation alone offers any chance of relief for that group of cases to which the one we are considering belongs.

Goldwait suggests that we proceed as follows: With a curved external incision, which is practically the incision of Kocher, he enters the calcaneo-astragaloid joint, and carefully denudes the surfaces of both bones of their cartilage. That accomplished, through the same incision he opens the joint formed by the upper surface of the astragalus with the tibia and fibula. The opposed surfaces of this joint are also denuded. In order to obtain a more accurate approximation of these denuded surfaces an oblique osteotomy of the fibula extending into the ankle joint is performed. In this way a careful approximation of the denuded surfaces and subsequent ankylosis of the supra and infra-astragaloid joints is sought.

Whitman would proceed in this way: Through practically the same incision the astragalus is removed. A sufficient portion of the outer side of the calcaneus and of the cuboid is removed to permit them to enter the mortise of the tibia and fibula from which the cartilages have been peeled off. The sustentaculum tali is also removed. Then the foot is displaced backward on the leg so that the internal malleolus comes to lie in the hollow behind the scaphoid, made by the removal of the astragalus, while the external malleolus covers the calcaneo-cuboidal articulation. The foot is put up in plaster of Paris in full plantar flexion and the peroneal tendons implanted into the Achilles tendon close to the calcis.

Robert Jones has suggested that the operation be done in two steps. In the first step he corrects the calcaneus by making a three-inch incision along the inner side of the foot through which he removes a wedge of bone base upward upward from the upper surface of the astragalus and the scaphoid. By obliterating the excavation formed by the removal of this wedge any calcaneus deformity is corrected. Four weeks later through a posterior longitudinal incision a wedge is removed from the astragalus sufficiently large to permit the foot to be brought to a right angle with the leg. The tibia and fibula are denuded of cartilage and the whole immobilized for another month. Should there be some life in the calf muscles, instead of the second step, Mr. Jones



shortens the tendo Achilles and posterior capsule of the joint and removes the flap of redundant skin. Later massage of the gastrocnemius is prescribed.

Three years ago I performed an operation upon one of these patients which combined features of the two first operations. The immediate result obtained was gratifying. I will try to find the patient for you and present her at a subsequent meeting.

The third case is as follows: Otto, German, age 37. A layer of hardwood floors by occupation. Personal history negative. Gonorrhea five years ago. On April 3rd, 1890, slipped, was carrying timbers up a hill; felt a wrench in inner side of left knee. Sat down for twenty minutes and was all right. Three days later there was pain in same place, pain continued constantly, could move leg a little. Seven days after the first attack the leg began to swell. There was no fever but the leg looked white. Cold towels were put on by the doctor. Went to a hospital where cold compresses were used for two weeks. Leg reduced to normal size. The next morning it was massaged and the swelling returned. Knee injected with unknown composition under chloroform anesthesia. A week and a half later pus appeared so operation was performed. Nine incisions. Gangrene was feared. Patient was in the hospital for fourteen weeks. Three days after being discharged from the hospital the wounds opened again and pain returned on the inner side of leg and knee. Swelling with pus appeared on the inner side of the knee, curetted, wound healed. For one year the wounds remained healed and then the wound on inner side of thigh opened during the next two years. Then it was perfectly well except for slight limitation of flexion for six years. In 1898 rheumatism appeared on the inner side of the thigh above the knee. Every spring and fall the rheumatism returned, sometimes there would be slight swelling. In 1904 it began to open in one of the old incisions. For two weeks it was open under the knee, discharged pus, very painful until pus appeared on surface. Even deep respirations increased pain in knee. It then healed in two weeks. Thereafter the opening of sinuses in popliteal space occurred in spring and summer for four years, until this May. In June, operated, incisions in inner side of knee and outer aspect of thigh. Pus appeared, but this healed. Iodoform was injected into these wounds. An old wound opened and discharged iodoform. Healed up everywhere until the end of September. Since then has opened twice. Openings accompanied by high fever.

He comes to us to know what we can do for him. I would like very much to have you look at him and examine him. I present also Dr. Freytag's X-ray of the man's leg. Please note the deformed appearance of the patella, the remarkable thickening of the whole lower end of the femur and the indistinct, almost ragged, definition of the bone in the region of the popliteal space. On manipulation note that motion is present through perhaps 40°. Full extension is prevented by a contracture of the hamstrings; flexion is limited by the adhesion of the patella to the femur. A probe introduced into the only sinus remaining patent, and which is in the popliteal space, detects at a considerable depth the grating of a particle of carious bone. It would be a simple matter to curette out the carious bone, to divide the hamstrings in order to obtain full extension, and to free the patella from the femur and keep it free by injecting sterile olive oil, after the procedure of Baer. However, the man proposes to continue at his present vocation of a layer of hardwood floors,—in that event he is sure to have a return of his "deformity" no matter how successful we may be in correcting it. With regard to his carious bone, the question arises as to the nature of the lesion; if for the moment we exclude lues, is or

is not the man tuberculous? His local condition does not point that way, but his general appearance does. It would be well to have his chest gone over and a tuberculin test made. The latter has a negative value. Should this man's knee lesion prove to be tuberculous, I would advocate radical operative interference. Otherwise I believe he would be better off left alone except for a curetting of the carious bone at the bottom of his sinus.

#### Discussion.

Dr. Levison: The subject of flat-foot is one of great interest. Four or five years ago flat-foot was practically unknown to the rank and file of the medical profession. It was known only to the orthopedic surgeon and the man who sold instruments. To begin with, the name flat-foot is a misnomer because people with badly pronated and abducted feet oftentimes have no flat-foot at all. This is a point not generally understood. The general practitioner is familiar with the symptoms of this condition and he has the patients take off their shoes and stand in front of him and if the arches are high he believes that the foot is all right; whereas, as a matter of fact the height of the arch is of no importance in causing the symptoms from which these patients suffer. In other words, the one factor which causes the suffering of the patient, is the weight of the body, which instead of falling through the middle of the patella and the ankle, drops to the median side of the foot. As a consequence, the arching of the foot does not play the role that it is supposed to play; hence, when a patient is examined for the purpose of determining the presence of flat-foot, the clothes should be removed from the feet and legs above the knees. The patient should then stand up at the other end of the room and should be inspected from the front and the back; in this way only can a pronated foot be determined.

With regard to the etiology, Dr. Watkins has spoken of the fact that a long illness is a predisposing factor in the development of flat feet; my experience has confirmed this. Pregnancy, in my experience, is also a factor. Many women who have had apparently normal feet prior to their confinements, will consult their physician and will complain of severe backache. It is my opinion that many women have been treated for uterine conditions when the feet which were primarily at fault, were overlooked. I have seen several patients relieved by plates, who, following the puerperium have suffered from backache. In backache and headache, the feet are generally lost sight of. I can recall a patient who came to me for an intractable headache. His eyes had been examined and he had taken a trip around the world advised for neurasthenia, presumed to have been brought on by overwork, and it was only as he stood undressed before me, that I was able to recognize the fact that his feet were bad. I did not have much confidence in the opinion that his feet were the cause of his headache, but plates were ordered, since which time his headaches have not returned.

Another case was that of a girl of 18 whom I had operated upon for appendicitis; six weeks following the operation she returned on account of backache which was quite severe. It was seen that she had pronated feet for which plates were ordered. Her troubles subsided almost immediately following the wearing of the plates. Another factor having an important relation to the pronated foot, is the varicose ulcer and its associated varicose veins. These veins are generally removed by operation and they frequently recur, as do the varicose ulcers which are treated in many ways. Everything is done toward relieving these conditions but it is seldom that any attention is paid to the feet. In my private work, I do not treat varicose ulcers for many times they will heal without treatment if the feet are cared for. Varicose veins will frequently

act likewise. It is important that massage of the calves of the legs and of the feet be given. Exercises of the tibialis posticus are important. These can be given by having the patient raise himself on the outer side of the foot during which time he is to raise the body so that he is standing on his toes as well as on the outer border of the foot. These exercises are of the greatest importance in stimulating the venous circulation, which when properly looked after will often result in the cure of the varicose ulcers.

## A REVIEW OF THE TREATMENT OF GONORRHEAL INFLAMMATIONS BY THE USE OF SERA AND VACCINES.

By GEORGE E. EBRIGHT, M. D., San Francisco.

Deeming the time expedient to take an inventory of stock in this department of our therapeutic armamentarium I have reviewed the literature upon the subject in the last two years. The interesting metastatic manifestations of gonococcus infections, notably the arthritides, are presenting a very promising province for the exploitation of vaccine therapy—promising in consideration of its abstract principle—sufficiently promising in concrete instances to sustain the interest of the clinician and to induce him, despite much disappointment, to suspend his judgment till a ripper time.

Experimentation has been carried on along two lines, somewhat parallel in their essentials and similar in their results: the use of dead gonococci on the one hand and the use of antigenococcic serum on the other. In January, 1906, Rogers and Torry of Cornell (*Jr. A. M. A.*, January 27, 1906) reported upon the use of serum in the treatment of gonorrhea, in which are claimed cures in acute Neisser infections of the prostate, the epididymus, and joints. Two years later, Herbst of Chicago, (*Jr. A. M. A.*, May 23, 1908) using the same technic as Torry and Rogers arrives at a diametrically opposite conclusion regarding those metastatic infections that are acute. They all agree that serum is of no avail in acute urethritis but Herbst further finds that no other acute inflammations react favorably. He agrees with them regarding chronic joint inflammations as did also Uhle and Mackinney (*Jr. A. M. A.*, July 11, 1908). In such lesions the serum appeared to be of decided advantage. But the serum is no better in this respect than dead cultures, and the latter offer no dangers from anaphylaxis. Moreover the steps necessary to obtain the serum from the ram are more involved than the preparation of the dead cultures, and as the theoretical considerations are met in the use of either, it is probable that experimentation will be limited to the simpler of the two.

While there have been reports on the use of vaccines by Ballenger (*Jr. A. M. A.*, May 30, 1908), Vail (*Jr. A. M. A.*, November 23, 1907), Shropshire (*Alabama Med. Jr.*, May, 1908), and a few others, by far the most elaborate exposition of the subject has been made by E. E. Irons of Chicago in two very interesting articles (*Archives Int. Med.*, Vol. I, No. 4, and *Jr. Infectious Diseases*, Boston, June, 1908), in which he adds 31 cases of joints to the 15 previously reported by Cole and Meakins (*Johns Hopkins Hospital Bul.*, 1907, 18, p. 223).

In the preparation of vaccines a heterologous strain is preferred, as a homologous strain is neither practicable nor necessary. Irons' earlier doses were 20 to 50 million organisms, but subsequently he preferred 100 to 500 million given at intervals of three to seven days. There is now a tendency to revert to smaller doses of 10 million and upwards.

Ruth Vail in a series of normal individuals found the opsonic index for gonococci to be an average of 1.0. Irons studied the opsonic index of 15 cases of gonorrheal joints and found the average below 1.0. This rises sharply after the injection of vaccine though sometimes falling at first. Dr. Vail who used only small doses did not observe the negative phase either clinically or microscopically. Irons, on the other hand, describes a reaction similar to the tuberculin reaction, after large doses, and this reaction corresponds to the negative phase. The reaction is characterized by fever, often only slight, an increase of pain and tenderness in the inflamed joints, occasionally an increase of swelling and a variable degree of malaise. It takes place within 8 to 12 hours and lasts about 24 hours. He has also noticed a local skin reaction in some cases at the site of the injection. I have endeavored in a number of patients with acute gonorrheal urethritis and arthritis to obtain this skin reaction after the manner of von Pirquet in tuberculosis. To this end a slight scarification was made on the arm of the patient and a drop of dead culture rubbed in. The results were failures. The extent to which the reaction following the subcutaneous injection of the vaccine is available for diagnostic purposes, requires determination by more extensive observations. There is one rather remote danger to be borne in mind in the use of this material which rests upon the occasional occurrence of gonorrheal iritis. Should a patient so afflicted be given a dose of serum or vaccine sufficiently large to produce a general reaction, the focal reaction in the inflamed iris may assume very grave proportions. This occurred in a case that was brought to my attention.

The only Neisser inflammation which responds to the use of dead gonococci with sufficient uniformity to place the treatment on anything like a secure plane is that of the joints. Whether better results are to be expected in chronic than in acute cases is a point upon which recorded observations do not yet allow a satisfactory decision. As to the permanent position of gonorrheal vaccine as a therapeutic agent the more conservative observers indulge only in guarded statements, but it is easy to detect a feeling that in the treatment of these arthritides the use of dead bacteria marks a very decided advance over the older methods. Other rational treatment is by no means to be discarded. Massage of the prostate and aspiration of the joints are still to be used in connection with the vaccines. It will be remembered in this connection that massage of the prostate in a chronic case where the opsonic index is low will at once cause a sharp positive phase, and the same holds true of manipulation of inflamed joints.

The action of dead cultures of gonococci in cases of arthritis in the relief of symptoms, especially pain,

is often very prompt, sometimes dramatically so as the following instance illustrates: A teamster, 21 years old, came to our wards having had urethritis one month and very severe pain in both knees for four days.

Examination showed that both knee joints contained much fluid, were very painful and so exquisitely tender that the slightest jar caused the patient to wince pitifully. One knee joint was aspirated and 40 cubic centimeters of turbid fluid was withdrawn in which gonococci were easily demonstrated.

The next morning the relief following the removal of the fluid had gone, the aspirated joint was as tense as before, both knees being greatly distended with fluid and causing as much suffering as ever. Salicylates in large doses had had no effect and were discontinued. Ten million dead gonococci were given subcutaneously in the arm and the interne instructed to withdraw the fluid from both knee joints the following morning if the condition was no better. This, however, proved to be unnecessary. By the end of twenty-four hours the clinical picture was entirely changed. The pain and tenderness had gone and the joints instead of being hot, hard and tense were cool and relaxed, the fluid having greatly receded. By the end of six days the fluid was still demonstrable but the patient was walking about the ward. He was given ten million more dead gonococci and within a few days no exudation in the joints could be detected. Recovery was considered complete in 16 days after the first injection.

#### MAJOR EMERGENCY OPERATIONS WITH REFERENCE TO FRACTURE OF THE SKULL AND WOUNDS OF THE ABDOMEN.\*

By WALLACE I. TERRY, M. D., San Francisco.

During the year Sept. 25, 1907, to Sept. 26, 1908, I have performed 45 major emergency operations at the Central Emergency Hospital, and it is my privilege to make some report of the cases to this society. As the total number of cases treated at the Emergency Hospitals during that time was approximately 20,000, it is to be understood that the 45 cases represented only the urgent major surgical conditions.

The cases may be roughly grouped into five classes, viz: 1. Acute Appendicitis; 2. Strangulated Hernia; 3. Severe Injuries of the Extremities; 4. Fractures of the Skull; 5. Wounds of the Abdomen.

There were two cases of acute appendicitis, both of which recovered.

Of the four cases of strangulated hernia one died—a man aged 69 years in poor physical condition with a very large scrotal hernia which had been irreducible for two days. At the operation a large coil of small intestine was found in the sac—no gangrene—intestine was reduced and hernial opening closed. Patient died quite suddenly four hours afterwards.

\*Read before the San Francisco County Medical Society.

There were ten cases of severe injuries of the extremities demanding immediate operation. Of these three patients died—a crush of the arm requiring amputation died after sixteen days from septicemia—a crush of both thighs requiring double amputation died in twenty-four hours from shock—a crush of one thigh requiring amputation died three days later with gangrene of the stump. Of the seven patients who recovered five required major amputations and two were conservatively treated.

Fracture of the skull furnished sixteen cases of which ten died. This mortality rate seems unusually high, but in explanation I would state that operations were only performed when imperative, the far greater proportion of such cases having been attended by their own physician. As a consequence the operated cases were of the most severe type and in a number of them operation was done with little expectation of a favorable outcome. The gravity of these cases is further shown by the fact that in all the fatal ones a basal fracture was present, as demonstrated at the operation or by autopsy. In several instances the middle meningeal artery was ruptured at the foramen spinosum. The average duration of life after operation in the ten fatal cases was forty hours, one patient having survived six days. Of the six cases which recovered two had ruptures of the superior longitudinal sinus.

A few words in regard to diagnosis may not be amiss. The differential diagnosis between acute alcoholism and fracture of the skull has been and is still a matter of great difficulty in a small proportion of cases. Where the two conditions coexist only careful observation over a considerable number of hours will enable one to arrive at a correct diagnosis. Blame should not too lightly be put on the emergency surgeons for an error in diagnosis when the period of observation is short and the difficulties of the case are considered. Lumbar puncture is of much value in some of the doubtful cases but too much weight should not be laid on it, as blood cells may not be present in the spinal fluid in a real case of skull fracture or on the other hand blood may be present as the result of puncturing a vessel. It should not be omitted, however, in suspicious cases. A study of the eye reflexes and of the fundus is often of great value. It should be remembered, however, that pupillary changes are often rapid and apparently contradictory in many of the borderline cases—at one moment we may find marked dilation of one pupil and soon afterwards both pupils may be equal and responsive to light.

In this connection I desire to mention that in two cases I have observed an irregular dilation of one pupil which later became regularly dilated showing that it was probably not due to an old syphilitic iritis nor to synechia. As the observations were brief and the history relative to any antecedent eye trouble not obtainable, I do not attach any special importance to them. Examinations of the fundus should be made by one thoroughly familiar with the normal and pathologic appearances, for the determination of beginning changes requires much practice. Suggillations, especially in the re-



gion of the mastoid, are suggestive of basal fractures, but may appear too late to be of diagnostic importance. More often hemorrhages or the flow of cerebro-spinal fluid from the nasopharynx or ears will give positive indications of skull injury, provided of course that purely local causes for the hemorrhages can be excluded.

So far as treatment is concerned there is little new to be said, except as regards Harvey Cushing's subtemporal decompression in basal fractures and the administration of hexamethylenamina. The idea of giving the brain an opportunity to expand and the extravasated blood or serum to drain away before the respiratory or other vital centers are fatally compressed seems rational, and Cushing's method is simple, easy of performance and will, in my opinion, be followed by a fair proportion of recoveries in what would ordinarily be considered hopeless cases. A straight incision in the direction of the fibers of the temporal muscle with splitting of the muscle permits ready access to the temporal and sphenoid bones and after decompression and drainage the temporal muscle protects the skull defect. Should the pathological findings on one side be insufficient to account for the symptoms, one should not hesitate to make a subtemporal opening on the other side. In his recent paper (*Annals of Surgery*—May, '08), Cushing reports 13 recoveries in 15 cases of basal fracture treated by this method.

The use of hexamethylenamina, after fractures of the skull to prevent meningitis has been advocated by Cushing following the discovery by Crowe that formaldehyde, one of its constituents, is found in the cerebro-spinal fluid soon after its administration. It should be given in large doses where we have reason to fear infection of the meninges.

There were thirteen abdominal wounds in this series of cases and of these ten were gunshot, one a stab wound, one a crush of the intestines and one a spontaneous rupture of the rectum. Nine cases terminated fatally after periods varying from a few hours to seven months. The organs involved in the fatal cases included the lungs, diaphragm, liver, stomach, pancreas, small and large intestine and the spinal cord, while in the four recoveries, the lungs, diaphragm, liver, stomach, large intestine and bladder were involved.

One gunshot case is sufficiently unusual to justify separate comment.

Mr. M. was shot in the abdomen with a small caliber bullet at midnight Feb. 10, 1908. The wound of entrance was at the outer border of the left rectus muscle at the costal margin—no wound of exit, but a prominence in the left triangle of Petit. Marked shock, rigid abdominal walls, bloody vomitus and the direction of the wound made the diagnosis of perforation of the stomach quite certain. At the operation which was performed about two hours after the injury, both the anterior and posterior walls of the stomach were found to be perforated and also the tail of the pancreas. The stomach wounds were sutured and the lesser peritoneal sac and pancreatic wound drained through a posterior incision just below the left kidney. The patient then came under the care of Dr. Emmet Rixford and apparently recovered after the first few weeks, except for a fistulous opening at the wound entrance.

This fistula persisted up to the time of his death seven months after the original operation.

At the autopsy by Coroner's Physician John R. Clark, to whom I wish to express my appreciation for the report of this and other cases, a general peritonitis with multiple abscesses of the liver was found. It is my belief that the pancreatic wound was the principal factor in the production of the late peritonitis though the condition of the organs was such that this point could not be determined at autopsy.

A case of subcutaneous rupture of the intestines is also of interest. Mr. D., a carpenter, fell from a ladder about 20 feet, landing on his back. A heavy panel fell on top of him, striking edgewise on the left side of the abdomen. The skin was not broken but the abdominal muscles were ruptured on the left side. At operation it was found that a loop of small intestine was cut across in two places about two feet apart up to the root of the mesentery. The descending colon and sigmoid were stripped from their mesentery but not ruptured. Much fecal matter and blood in the abdomen. An excision of that portion of the small intestine between the two ruptures followed by an end to end anastomosis was rapidly done and the descending colon brought out of the wound. Death in twenty-four hours. At autopsy besides the above mentioned injuries the psoas and iliacus muscles were found to be pulped and the left ureter crushed.

A case of rectal perforation presented simply the picture of a general peritonitis with a history of having been sick for two days. At operation a perforation of the anterior wall of the rectum nearly  $\frac{1}{2}$ " in diameter was found. The presence of cicatrices in the descending and sigmoid colon make it probable that an old dysentery or lues was responsible for the perforation.

As regards gunshot wounds of the abdomen the consensus of opinion favors immediate operative intervention when the wound has been produced by a bullet of large caliber traveling at a comparatively low velocity. The opposite rule prevails in military life where the bullet is small, has a hard jacket and the initial velocity is high, for in many instances, as shown by the records of recent wars, the visceral perforations close spontaneously and there is scarcely any soiling of the peritoneal cavity. In civil life the wounds are ragged, fragments of clothing and skin are carried in deeply and the contents of hollow viscera are more apt to leak into the peritoneal cavity.

In gunshot wounds of the stomach, the prognosis is materially influenced by the character of the contents of that organ. In a fasting state the gastric secretion is relatively sterile, but when, as often happens in civil life, the patient has eaten mixed foods poorly chewed and washed down with alcoholic beverages, the insult to the peritoneum is great.

The question of irrigation of the peritoneal cavity in the presence of extravasated intestinal contents is still debatable. There are many surgeons who insist that a dry toilet of the peritoneum is the better method, while some of the advocates of thorough irrigation have recently stated their convictions. Blake of New York seems to obtain as good results by washing the peritoneal cavity with normal salt solution, as do those who follow the opposite method. Personally I am yet unable to decide to my own satisfaction which is the better method.

## Discussion.

Dr. Hobdy: In the matter of peritoneal toilet I am firmly convinced of the efficacy of the wet method, not only washing out thoroughly, but after making the peritoneal toilet as thoroughly as possible, leaving in a certain amount of fluid in the peritoneal cavity. The cases which I have seen under this treatment, have shown better results than when an attempt has been made to clean a soiled peritoneum by the dry method.

Dr. Barbat: One thing which has attracted my attention in injuries to the head is the disproportion between the symptoms and the amount of injury to the brain. I have seen several of these cases recently. In the case of a patient who had been hit by a street car, there were seven consultants, none of whom would venture an opinion as to the locality or extent of the brain lesion, but we decided to explore and find out. An opening was made over the site of injury and a linear fracture of the skull found extending from a little above the top of the ear to the base of the skull. On opening the skull the whole temporosphenoidal lobe was found to be pulvified, due to the rupture of a branch of the middle cerebral artery. Several hours before operation this man was able to get up on his elbow and ask for the urinal, and was apparently perfectly rational. I have noticed in several cases that individuals have been able to converse rationally with large amounts of brain tissue destroyed. We have a great deal to learn before we will be able to diagnose correctly whether a patient has an extradural or subdural hemorrhage, or is suffering from a destruction of brain tissue due to intracerebral hemorrhage.

Dr. Somers: I was very glad to hear this paper by Dr. Terry on the subject of fractures of the skull and other cases that come under the observation of an emergency surgeon. Of the various groups of cases that come under observation in emergency work it appears to me that these cases of fracture of the skull are the most interesting. A man that is dealing with this class of cases is constantly bumping up against the question as to whether a man is merely drunk or dying from some more serious condition. I notice that Dr. Terry spoke with some little feeling about the difficulties of diagnosis in this class of cases. Where emergency work is not well organized, cases of this sort are constantly slipping through the fingers of the emergency surgeon to the great joy of the newspapers. I have not noticed anything recently in regard to "drunk or dying" cases, but a few years ago a great many such seemed to come before our notice. Often the only way that we can make a diagnosis is to keep the cases under observation for a number of hours, or even days, perhaps, and the only way that the service can prevent the slipping through of these is to realize and insist upon the fact that a man who is drunk is suffering from a poison; that he is poisoned and as such is properly in the hands of the medical profession and should not be turned over to the police until he is sober. As regards the procedure where diagnosis of fracture of the skull is made, I believe that as soon as that diagnosis is made an operation should be performed,—the skull should be trephined. The necessity of trephining is well illustrated by a case which I remember of a small boy who fell down the second story of a building and whom I saw a few hours after he fell. He had regained consciousness but for several days did not attain complete mental equilibrium. After careful study it seemed to me that he was suffering from a fractured skull. This case fell into my hands after I had had my experience in emergency work and following the routine of my experience, I advised operation. A linear fracture across the parietal bone was found without any depression or separation. However, there seemed to be considerable oozing from that line and upon trephining, I found very distinctly, a

portion of the dura mater caught up between the two fragments of bone. In other words, when the child fell, the bone was fractured, the parts separated, the dura mater came between and was caught there. By a simple opening the dura mater was liberated and the child recovered. These two points in reference to skull cases, I would emphasize, viz.—where alcoholism is a complicating symptom, that case must be kept under observation whether the lesions are found or not, and secondly, the necessity of trephining wherever a case of fracture is diagnosed, for there is always the danger of pinching the dura mater even in a linear fracture.

## UROPHERIN-S.

Uropherin-Sr,  $\text{LiC}_7\text{H}_7\text{N}_2\text{O}_2 + \text{LiC}_7\text{H}_7\text{O}_2$ , is a double salt of theobromine-lithium and lithium salicylate.

Actions and Uses.—The properties, actions, uses and dosage of this compound are practically the same as those of "theobromine-lithium benzoate" (see Uropherin-B). Manufactured by E. Merck, Darmstadt (Merck & Co., New York).

## UROTROPINE.

A name applied to Hexamethylenamina, U. S. P. UROTROPINE—NEW.

A name applied to Hexamethylenamine Methylenecitrate (which see). Manufactured by Chemische Fabrik auf Actien, vorm. E. Schering, Berlin (Schering & Glatz, New York).

## VALYL.

Valyl,  $\text{C}_4\text{H}_9\text{CO.N}(\text{C}_2\text{H}_5)_2 = \text{C}_4\text{H}_9\text{ON}$ , is a compound of valeric acid and diethylamine.

Actions and Uses.—Valyl acts as a sedative, antispasmodic and nervine, similar to valerian. Dosage.—Owing to the liability of valyl to oxidize when exposed to the air, it is supplied only in the form of gelatin capsules, each containing 0.125 Gm. (2 grains), the dose being 2 or 3 capsules, administered during or immediately after meals, or otherwise with a little milk. Manufactured by Farbwerke, vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

## HOME NURSING COURSE FOR WOMEN.

The nurses' auxiliary of the California branch of the American Red Cross has undertaken an exceedingly valuable work. A series of lectures have been arranged for housewives and women generally, intended to give the woman at home an idea as to the care of members of the family when taken sick, without in any way infringing upon the territory of the trained nurse. Miss Frances S. Hirschey, 449 Cole St., San Francisco, is the Secretary, and full information can be had from her upon application.

## PHYSICIANS' MUTUAL AID ASSOCIATION.

This exceedingly valuable organization was started in California some few years ago, and has not met with the support which it really should. It provides assistance to physicians who are members in case of need and, on the assessment plan, pays a small death benefit. It is inexpensive to keep up, and it should receive a more hearty support from our members.

Write to Dr. J. E. Janes, Secretary, Pasadena, Cal., and find out about it.

## UNIVERSITY COURSE IN HYGIENE.

The State University has established this year a course in hygiene at the Summer Session from June 21st to July 31st. The work is in charge of Dr. Ernest B. Hoag, Medical Director of the Pasadena City schools, and Margaret Henderson, assistant in bacteriology. There are courses on school hygiene, medical inspection in schools, elements in bacteriology and bacteriological diagnosis. The last two are from 9:00 to 12:00 in the morning, Monday, Tuesday, Wednesday, Thursday and Friday. The first is on the same days at 2:00 in the afternoon, and the second at 3:00 in the afternoon. These courses should be very attractive.

### The Relief of Dr. Carroll's Widow.

Washington, D. C., March 29, 1909.

To the Medical Profession:—The following resolution was adopted by the Legislative Council of the American Medical Association at its meeting in Washington, D. C., in January, 1909:

"Resolved, That a committee composed of one member of the Medical Department of the Army, one of the Medical Department of the Navy, one of the Public Health and Marine-Hospital Service, one member of the District of Columbia Medical Society, and one member to represent the profession at large, members of the council, be named by the chairman, and instructed to present to the different medical services of the government, the District of Columbia, and the profession at large the conditions of distress under which the widow of our hero brother, Major James Carroll, is placed, and suggest or help to devise such plan and action as may speedily bring relief."

The chairman appointed the following committee: Major M. W. Ireland, U. S. Army; Surgeon W. H. Bell, U. S. Navy; Surgeon John F. Anderson, U. S. P. H. and M. H. S.; Dr. John D. Thomas, District of Columbia; Dr. A. S. von Mansfelde, Nebraska.

At the death of Major Carroll, Sept. 16, 1907, his family was left practically unprovided for. There was a small insurance policy, and a short time prior to his death Major Carroll had begun making payments toward the purchase of a home in Washington. A mortgage of \$5,000 remains unpaid on the house and a further debt of \$2,300 secured by notes payable at the rate of \$50 a month. Congress allowed Mrs. Carroll \$125 a month, and on this amount depends the support of herself, the aged mother of Major Carroll and seven minor children. It is utterly impossible for her to make the payments on the house, and unless assistance is speedily forthcoming she will lose it.

It is certainly needless to repeat to the members of the medical profession of this country the distinguished service of Major Carroll as a member of the yellow-fever board in Havana when he submitted to an experiment to prove that the disease was transmitted by a mosquito. He suffered a severe attack of yellow fever and for a time his life was despaired of. This illness left him with a disabled heart, which eventually cost him his life. It is believed that every physician is willing to contribute toward saving the home of the widow and orphans of this hero.

In response to this resolution, your assistance is invited toward the attainment of the worthy object expressed in the above resolution.

The following contributions to the Carroll fund have been received:

Officers of the Medical Corps, U. S. Army...	\$1,500.00
Officers of the Medical Dept., U. S. Navy...	400.00
Officers of the U. S. P. H. and M. H. S. ....	300.00
Officers of the District of Columbia.....	210.00
Mrs. Frances E. Hand, New York City.....	50.00
Dr. Eugene A. Crockett, 298 Marlborough St., Boston .....	5.00
Dr. Edmund A. Christian, Supt., Eastern Michigan Asylum, Pontiac, Mich.....	1.00
Dr. W. E. Clark, Frederick, S. D.....	5.00
Dr. George W. Gay, 665 Boylston St., Boston .....	10.00
Dr. L. Hektoen, Memorial Institute for Infectious Diseases, Chicago.....	5.00
Dr. Emil King, Fulda, Minn.....	1.00
Dr. John A. Koch, Quincy, Ill.....	5.00
Fountain and Warren Medical Society, Attica, Ind .....	12.95
	<hr/>
	\$2,504.95

M. W. IRELAND, Chairman.

[Contributions for this fund are earnestly re-

quested from physicians. Make checks, drafts, etc., payable to Major M. W. Ireland and send them to him at the office of the Surgeon-General, War Department, Washington, D. C. Acknowledgment of subscriptions will be made in "The Journal."] Reprinted from The Journal of the American Medical Association, April 3, 1909, Vol. LII, p. 1122.

## COUNTY SOCIETIES

### BUTTE COUNTY.

The regular meeting of the Butte County Medical Society was held March 9th at the offices of Dr. N. T. Enloe. Members present, Drs. N. T. Enloe, P. F. Bullington, D. H. Moulton, H. M. Parker, H. Morel, M. Stansbury, W. L. Gatchell, E. F. Gatchell and Edw. Baumeister, visitor.

A paper on treatment of Ophthalmia Neonatorum was read by H. M. Parker, and discussed by other physicians. The subject of Medical Defense as a feature of the State Medical Society membership was discussed and the society voted to endorse the proposition. The society also voted to subscribe for two foreign journals. Dr. H. Morel to translate for the society such articles as were desired, one journal to be therapeutic and the other treating on surgery. Voted to hold the April meeting at Oroville if time of meeting and transportation could be arranged. Following the meeting the members were the guests of Dr. Enloe at supper at the Hotel Diamond.

ELLA F. GATCHELL, Secretary.

### SAN JOAQUIN VALLEY SOCIETY.

The San Joaquin Valley Medical Society met in the Chamber of Commerce rooms in Stockton, March 9th. The morning hours were turned over to the Central California Health Officers' Association. The following papers were read:

"Tuberculosis, with some suggestions on treatment.—C. C. Browning, M. D., Monrovia, Cal.

"Pure Food Law and its Operation."—Prof. M. E. Jaffa, (Director State Food Laboratory), Berkeley, Calif.

"California Sulphured Fruits and their effects on the Human System."—Albert A. Atkins, M. D., San Francisco, Calif.

These papers were well received and the discussion on them was favorable.

In the afternoon the program of the San Joaquin Valley Medical Society was taken up and the papers read were as follows:

"A Report of Several Cases of Nephritis with unusual features," C. R. Harry, M. D., Stockton, Cal.

"A Plea for Early Operation on the Stomach with Cal.

"The Malarial Zone," D. F. Ray, M. D., Stockton, Cal.

"Rheumatism, and its relation to diseases of the throat," B. F. Walker, M. D., Stockton, Cal.

The members of the Society were taken to lunch in the Elks' Hall at noon and in the evening a banquet was tendered the San Joaquin Valley Medical Society by the San Joaquin County Medical Society. The members of the profession in Stockton did everything in their power to make the members of the Society enjoy themselves while in Stockton. In addition to the aforementioned lunch and banquet, the members enjoyed an auto ride around the town and over their section of macadamized roads.

The following officers were elected for the next meeting:

Dr. J. R. Walker, president; Dr. R. W. Musgrave, 1st vice-president; Dr. R. E. Dixon, 2nd vice-president; Dr. C. T. Rosson, 3rd vice-president; Dr. D. H. Trowbridge, secretary; Dr. W. W. Cross, assistant secretary; Dr. T. M. Hayden, treasurer.

The next meeting will be held in October at Han-

D. H. TROWBRIDGE, Secy.



**SANTA BARBARA COUNTY.**

The Santa Barbara County Medical Society met in regular session at the Chamber of Commerce, March 9th at 8 p. m. Dr. Eugene A. Dial in the chair; the Secretary, Dr. Barry, at his desk. The following members were present: Drs. Barry, Brown, Dial, Hindley, Holt, Sheaff, T. A. Stoddard; visitors,—J. H. Hester, veterinary surgeon, Miss A. L. Frisby, from visiting nurses' association and others.

The subject for the evening was "Pediatrics" (a symposium arranged by Dr. W. L. Holt). The following papers were presented:

1. The Problem of Breast Feeding—W. L. Holt, M. D.
2. Surgical Treatment Acute Anterior Poliomyelitis—R. Brown, M. D.
3. The need of a Visiting Nurse in Santa Barbara—Miss Frisby.
4. The Use of Goat's Milk—J. H. Hester, V. S.

Some interesting clinical cases were presented, and the papers read discussed. The Society is just entering upon a new year and we are hopeful of increased interest and improved attendance.

W. T. BARRY, M. D., Secretary.

**SONOMA COUNTY.**

Sonoma County Society met in regular session on April 2nd at the City Hall, Petaluma. Dr. E. Gray resigned as Delegate, and Dr. W. J. G. Dawson was elected to fill out his term.

Dr. Geo. H. Evans of San Francisco, spoke on the subject of the White Plague. He referred to the serious danger which existed a year ago from Bubonic Plague, and called attention to the fact that while only 54 persons died from Bubonic Plague, 880 died in San Francisco from consumption.

Dr. J. Henry Barbat discussed the question of tuberculosis in bones and joints. Both papers were highly appreciated and extensively discussed.

Dr. A. R. Graham, Petaluma, was reinstated, and Drs. J. E. Maddox, Sebastopol, and F. N. Folsom, Forestville, were elected to membership. Applications were received from Dr. M. B. McAuley and Dr. Fred Leix.

The next meeting will be held in Healdsburg, May 7th, 1909.

G. W. MALLORY, Secretary.

**NEW AND NON-OFFICIAL REMEDIES.**

Articles accepted for N. N. R.:

- Enzymol (Fairchild Bros. & Foster).
- Sabromin (Farbenfabriken of Elberfeld Co.)
- Medinal Tablets, 5 grains (Schering & Glatz).
- Pituitary Substance (Anterior Lobe) (Desiccated) Armour & Co.
- Pituitary Substance (Posterior Lobe) (Desiccated) Armour & Co.
- Parathyroid Gland (Desiccated) Armour & Co.

Articles accepted for N. N. R. Appendix:

- Compressed Tablets Anesthesin  $2\frac{1}{2}$  grains \* (Sharp & Dohme).
- Solution Atoxyl 10% (Sharp & Dohme).
- Solution Atoxyl 10% with Novocaine 1% (Sharp & Dohme).
- Compressed Tablets Atoxyl and Quinine Comp., (Sharp & Dohme).
- Compressed Tablets Benzosol  $2\frac{1}{2}$  grains (Sharp & Dohme).
- Compressed Tablets Benzosol and Codein (Sharp & Dohme).
- Compressed Tablets Blaud with Atoxyl (Sharp & Dohme).
- Compressed Lozenges, Orthoform, 1 grain (Sharp & Dohme).
- Compressed Tablets Pyramidon  $1\frac{1}{2}$  grains (Sharp & Dohme).

Articles reconsidered and rejected:

- Salit (Heyden Chemical Works).

Transfer of Agency:

- Stovaine (formerly sold by Walter F. Sykes, New York, now sold by the Parmele Pharinaal Co.)

**A PUBLIC HEALTH CAR.**

The following models and charts will be arranged by Doctors Foster and Snow, and are installed in a remodeled chair car, and were on the siding at San Jose, two blocks from Hotel Vendome, during the meeting of the State Society.

**Models of:—**

1. A kitchen operating room.
2. Ventilation of a room, 2 illustrations.
3. Room arranged for isolation of communicable diseases.
4. Sand filter for water supplies.
5. Garbage Incinerator (pit and cone method).
6. Septic tank.
7. Butcher shop and tenement of tuberculosis patient.
8. Room in disinfection.
9. Tent for Tuberculosis case.
10. Frame for Tuberculosis case.
11. Five other fresh air contrivances.
12. Polluted surface well.
13. Polluted lake.
14. Series, 6 models, polluted stream.
15. Average California dairy, (one half as they exist, other half showing improvements that should be made).
16. Farm house, showing conditions, following tuberculosis and typhoid.
17. Disposal of human excretion series.
18. Cuspidors, etc.
19. Tombstone series.
20. Miscellaneous small models of various sanitary devices, etc.

**CHARTS.** Showing occupations, vital statistics of California, etc. About 20 charts 30 by 40 inches and 100 charts 20 by 30 and 14 by 22 inches individually.

**AMERICAN PROCTOLOGIC SOCIETY.**

This Society Will Hold Its Eleventh Annual Meeting at Atlantic City, N. J., June 7 and 8, 1909.

Headquarters and place of meeting, Haddon Hall. The profession is cordially invited to attend all meetings.

**TO MEMBERS OF THE TUBERCULOSIS ASSOCIATION.**

To the Members of the California Association for the Study and Prevention of Tuberculosis:—At the suggestion of Mr. C. B. Boothe, the American Association for International Conciliation will be glad to send the documents of the Association as published to the members of the California Association for the Study and Prevention of Tuberculosis who signify their desire to have this done.

The documents, which are issued monthly, are designed to furnish brief but authoritative statements of various aspects of international relations and are distributed without charge, post-paid, to all persons upon the mailing list of the Association.

F. P. KEPPEL, Secretary,  
Sub-station 84, New York City.

**PUBLICATIONS.**

**New and Nonofficial Remedies.** Articles Which Have Been Accepted by the Council on Pharmacy and Chemistry of the American Medical Association, Prior to January 1909. Chicago: Press of the American Medical Association, 103 Dearborn Avenue. Paper, 25c; cloth, 50c.

This is the first regular edition of the Annual New and Nonofficial Remedies, and it contains a list of the remedial preparations approved by the Council on Pharmacy and Chemistry of the American Medical Association. Instead of adhering strictly to an alphabetic arrangement a classification has been adopted which permits an easy comparison of remedies of similar origin and properties. Mixtures are to be found in the appendix and a number of non-

proprietary preparations have been added which, for various reasons, have not been admitted to the Pharmacopeia. The descriptions in the appendix have been made as brief as possible and the articles are classified under the names of the manufacturers. Therapeutic indications are not given, as it is assumed that the physician is able to apply his knowledge of the pharmacologic properties of the ingredients without aids from either the Council or the manufacturer. The non-proprietary remedies admitted to the body of the book are described as accurately and carefully as a painstaking search of the literature would permit.

The descriptions of processes of preparations, chemical and physical, and of the physiologic action contain much information which can not fail to be of immense value both to physicians and to pharmacists.

Over 200 different remedies are described, and after mastering the Pharmacopeia the practitioner and the student should become thoroughly familiar with this presentation of the newer materia medica.

**Essentials of Medicine.** A Text Book of Medicines for Students Beginning a Medical Course, for Nurses, and for All Others Interested in the Cure of the Sick. By Charles Phillips Emerson, M. D., Late Resident Physician the Johns Hopkins Hospital, and Associate in Medicine the Johns Hopkins University. J. B. Lippincott Company.

"Many are published, but few are chosen," might well be said of the many medical text-books which adorn the shelves of our stores and libraries, most of which, excepting of course our well-known standards, enjoy but a very scant popularity. Emerson's work is going to be one of those chosen, for it really and truly "fills a long-felt want." To be sure it does not bring any new facts, nor present anything not found in the usual books placed at the disposal of the student. That is not its purpose. In it we find a very happy combination of anatomy, physiology, pathology, bacteriology, hygiene, diagnosis and medicine,—all so well expressed, so simply written and so logically put, that anybody with but a high school education can understand every word of it. A great many people interested in their own bodies, their own illnesses, or even in medicine itself, unable to devote months to the reading of the usual works on these subjects, surely will hail this book with delight. Besides it teaches just what the profession should want the layman to know, i. e., what disease is, its prophylaxis, and what the physician can do in case of illness, not to mention the difference between a poor and a good doctor. As Emerson says, it is especially for the students of medicine, who frequently lack perspective in their medical studies, who do not learn the A. B. C. of the disease before proceeding to its more difficult study, as well as for nurses who know a great deal in a general, indefinite, inaccurate way, that he has written the book. Those physicians, whose hospital positions entitle them to lecture to nurses, would do well to see what Emerson's experience has taught him to be essential, rather than to continue wasting time and energy, as many do, upon a lot of details which the nurse can never understand or never use. And lastly, we are certain that there are many older men who for years have done but little reading, who will conclude that this book really gives a refreshing presentation of what constitutes our modern conceptions of disease.

R. B.

**Pain: Its Causation; Diagnostic Significance in Internal Diseases.** By Dr. R. Schmidt. Translated by Karl Vogel and H. Zinsser. Appleton, 1908.

This book is a serious attempt to analyze the causes of pain. It is evidently based upon a wide clinical experience and contains much that the diagnostician will find of distinct service. A short chapter based upon the work of Head and Mackenzie has been added, and Head's diagrams as well as many serviceable figures illustrating the chief sites of special pains are appended. The translation has been well done, and we heartily commend the book.

**Retinitis Pigmentosa With an Analysis of Seventeen Cases Occurring in Deaf Mutes.** By William

T. Shoemaker, M. D., Philadelphia. Laboratory Examinations of the Blood and Urine by John M. Swan, M. D. The J. B. Lippincott Co.

After having read this monograph one can well sympathize with the donors in awarding the Alvarenga prize to Dr. Shoemaker. Seventeen cases are analyzed minutely with their histories, local and general examinations and laboratory findings of the blood and excreta. Each case is considered first individually and then all are summarized collectively. A full digest of the literature is given and all pertaining to the etiology, symptomatology, prognosis and treatment of this interesting though comparatively rare condition is considered. Though practically nothing new is added to the existing knowledge of the subject Dr. Shoemaker has left nothing unsaid. The illustrations are excellent. A work of this character is an example of painstaking thoroughness and a credit to American literature.

W. S. F.

**Subcutaneous Hydrocarbon Protheses.** By F. Strange Kolle, M. D., Author of "The Recent Rontgen Discovery"; "The X-Rays, Their Production and Application"; "Medico-Surgical Radiography," Etc., Etc. The Grafton Press, New York.

Dr. Kolle remarks in his foreword that this volume was written to systematize our knowledge of this important branch of plastic surgery. His work is a digest of the literature of paraffine injections to date, to which is added his own experience of several prosthetic operations.

The book has no table of contents but is supplied with a very good index. Beginning with a short history of the subcutaneous use of oil and liquefied paraffine, Dr. Kolle gives the general indications for its use. In his precautions he wisely counsels the operator against the hypercritical patient who not satisfied with a normal appearance may influence him to further efforts, thereby undoing the excellent result. Kolle writes emphatically against the use of a general or local anesthetic and favors oft repeated small injections. In very exceptional cases a spray of ethyl chloride may be used over the site of the needle prick.

The various untoward results are considered in order with the author's recommendations for avoiding same. He feels that emboli, and particularly of the retinal vessels, are due to faulty technic or the use of paraffine of high melting point. A paraffine that is semisolid at 70° F. injected as a white cylindrical thread should avoid absolutely this unfortunate complication. The paraffine, its preparation and the instruments are all fully described.

A chapter is devoted to the sterilization of the patient and instruments; and then the regions of the body amenable to this form of correction are considered seriatim. The book is worth possessing and should prove an invaluable guide to one engaged in this work.

W. S. F.

**Lectures on Principles of Surgery**, by Stuart McGuire, M. D., Professor of Principles of Surgery and Clinical Surgery, University College of Medicine, Richmond, Va. Southern Medical Publishing Company, Baltimore, 1908.

In a book of 480 pages Dr. McGuire publishes the lectures delivered to his class. Not a single illustration illumines the text and there is little to interest the general reader outside of the arrangement of the subject matter which is excellent. He who reads critically will have reason for questioning many of the author's statements. The making of general statements in surgery is the hardest of tasks and, while it is evident that the writer has endeavored to simplify his subject in this way, he has gained his end only by a sacrifice of scientific accuracy. In the preface it is stated that the book is intended for the use of students and practitioners who desire the most recent views of surgical pathology, and yet the author briefly dismisses the Bier hyperemic treatment. In his conclusions he says, "At the present time the clearest indications for the treatment by hyperemia are found in cases of chronic inflammation when they are tuberculous in nature," a statement which must be held open to serious objection.

Has the purely didactic lecture a place in present day surgical teaching? If we look at the matter from the historical standpoint we will find that it carries the weight of authority. It was the method of Hippocrates, of Galen, of Celsus, of Guy de Chauliac, of Paracelsus. The keen observer, Ambroise Paré, published his greatest work, "Journeys in Diverse Places," in 1585 in response to an attack made upon him by Etienne Gourmelen, no less a personage than the Dean of the Medical Faculty of Paris. Gourmelen had written a book in which he had appealed to tradition to show that the use of the cautery for stanching blood after amputations was vastly superior to Paré's method of ligation. In his ironical rejoinder the barber surgeon says, "Moreover you say that you will teach me my lesson in the operations of surgery which I think you cannot do, for I did not learn them in my study or by hearing for many years the lectures of physicians." And then he recounts his enormous experience in city, in military camps and on battlefields, from which he concludes that, "the operations of surgery are learned by the eye and by the hand."

Paré was the first great surgical clinician and, though his life was not given to class instruction, his books teach the great value of close and accurate observation, a system which established independent thinking and threw aside the weight of authority which had bound surgeons to the Galenic wheel for fourteen hundred years. Surgery must be taught in operating room and in clinic. He who seeks knowledge must be immediately brought in contact with the text-book which he is to study for the rest of his life—the patient. We still bow too low to authority. We read too much; we see too little. The teacher is a guide to individual effort. If the student feels the need of a more connected picture than the clinical material at his disposal can give, the instructor must of necessity be forced to elaborate. But to describe the "set up" of an operating room in a course of didactic lectures is the last straw; teaching nursing by means of correspondence is on the same plan. R. R.

#### CHANGE OF ADDRESSES.

- Anton, F. L.**, from Pac. Mut. Bldg. of Los Angeles to Exchange Bldg., Los Angeles.
- Beckett, W. W.**, from Pac. Mut. Bldg. to Exchange Bldg., Los Angeles.
- Barber, D. C.**, from Security Bldg. Los Angeles to Byrne Bldg., Los Angeles.
- Bonyng, C. W.**, from Coulter Bldg., Los Angeles, to Union Trust Bldg., Los Angeles.
- Brainard, H. G.**, from Pacific Mut. Bldg., Los Angeles, to Exchange Bldg., Los Angeles.
- Brown, Newell J., Jr.**, from Stagg, Cal., to Ludlow, California.
- Colliver, Jno. A.**, from Bradbury Bldg. to Laughlin Bldg., Los Angeles.
- Colburn, John R.**, from Delta Bldg., Los Angeles, to Pacific Electric Bldg., Los Angeles.
- Byington, Frank S.**, from Citizens' National Bank to Wright & Callender Bldg., Los Angeles.
- Cook, John B.**, from H. W. Hellman Bldg., Los Angeles to Grosse Bldg., Los Angeles.
- Copeland, John C.**, from Florence, Cal., to 202½ So. Broadway, Los Angeles, Cal.
- Cowles, C. D.**, from 1101 N. Adams street, Los Angeles, to Wilcox Bldg., Los Angeles.
- Dale, H. M.**, from 3801 S. Main street, Los Angeles, to San Fernando Bldg., Los Angeles.
- Dickinson, J. C.**, from 2316 So. 7th street, Los Angeles, to Security Bldg., Los Angeles.
- Dudley, Wm. H.**, from Pacific Mutual Bldg. to Exchange Bldg., Los Angeles.
- Frasse, Irwin N.**, from Los Angeles to Soquel, Santa Cruz County, Cal.
- Garrison, Chas. G.**, from 905 So. Main street, Los Angeles, to 215 W. 16th street, Los Angeles.
- Hall, Edwin H.**, from County Hospital, Los Angeles to 428½ South Spring street, Los Angeles.
- Hatch, Raymond G.**, from Laughlin Bldg. to Wright & Callender Bldg., Los Angeles.
- Haynes, Robt. W.**, from H. W. Hellman Bldg., to Union Trust Bldg., Los Angeles.
- Holcombe, Arthur L.**, from Compton to 701½ Broadway, Los Angeles.
- Houghton, A. D.**, from Mason Bldg. to Baker Blk., Los Angeles, Cal.
- Hunter, Geo. G.**, from Pac. Mut. Life Bldg. Los Angeles, to Exchange Bldg., Los Angeles.
- Jenkins, J. F. T.**, from 2400 Hoover street, Los Angeles, to 1050 W. 24th street, Los Angeles.
- Jenkins, J. E.**, from 2400 Hoover street, Los Angeles, to 1050 W. 24th street, Los Angeles.
- Johnston, J. L.**, from I. W. Hellman Bldg., Los Angeles, to Bullard Bldg., Los Angeles.
- Lindley, Walter**, from 1414 So. Hope street, Los Angeles, to California Hospital, Los Angeles.
- Lowentrou, O. B.**, from Bryson Bldg. to Union Trust Bldg., Los Angeles.
- McCollough, A. M. F.**, from Trust Bldg. to Wilcox Bldg., Los Angeles.
- McNab, Thos. R.**, from Trust Bldg., Los Angeles, to Pacific Electric Bldg., Los Angeles.
- Moore, Ross J.**, from Pacific Mutual Bldg. to Exchange Bldg., Los Angeles.
- Morton, Geo.**, from Hollywood to Wright & Callender Bldg., Los Angeles.
- Newberry, Frank J.**, from O. T. Johnson Bldg. to Wright & Callender Bldg., Los Angeles.
- Norton, Frank L.**, from Mason Bldg. Los Angeles, to County Hospital, Los Angeles, Cal.
- Pahl, Peter C. H.**, from Lissner Bldg., Los Angeles, to Good Samaritan Hospital, Los Angeles.
- Philp, Wm. S.**, from Pacific Mutual Bldg., Los Angeles, to Exchange Bldg., Los Angeles.
- Rea, R. R.**, from Lankershim Bldg., Los Angeles, to Chamber of Commerce Bldg., Los Angeles.
- Reynolds, J. T.**, from 430 So. Broadway to Bryne Bldg., Los Angeles.
- Ross, M. H.**, from 16th and Main streets to Harwood Bldg., Los Angeles.
- Shaffner, Thos L.**, from Bryson Bldg., Los Angeles, to 145 So. Spring street, Los Angeles.
- Smith, Geo. B.**, from Pasadena to Hotel Van Nuys, Los Angeles, Cal.
- Smith, Rea**, from Bradbury Bldg. to O. T. Johnson Bldg., Los Angeles.
- Stinchfield, H. C.**, from O. T. Johnson Bldg. to Wright & Callender Bldg., Los Angeles, Cal.



- Taylor, Chas. S., from Douglas Bldg. to 403 South Hill street, Los Angeles.
- Trevalyn, Geo. H., from 943 Potter Park to 533 So. Grand Ave., Los Angeles, Cal.
- Wade, W. L., from 314 W. 4th street to 143 East Adams street, Los Angeles, Cal.
- Wagner, A. F., from 505 E. 15th street to 516 East Washington, Los Angeles.
- Watson, Chas. V. P., from 2652 W. Pico street to 2502 W. Pico, Los Angeles.
- West, Fred'k B., from 407 W. 7th street to Mason Opera House Bldg., Los Angeles.
- Hillegass, Geo. W., from Bacon Blk., Oakland, to 592 28th street, Oakland, Cal.
- Mitchell, F. P., from 466½ 13th street to Bacon Blk. Oakland, Cal.
- Morris, Morris M.**, from Auditorium Bldg., Los Angeles, to —?
- Purves, John, from Blake Blk. to Central Bank Bldg., Oakland, Cal.
- Hibbard, W. E.**, from Bradbury Bldg., Los Angeles, to Security Bldg., Los Angeles.
- Billingsley, U. C., from 6th ave. and California, to 3503 Mission street, San Francisco.
- Egeberg, Julius C., from 1403 Golden Gate Ave. to 910A Devisadero, San Francisco.
- Eidenmuller, Wm. C., Sr., office 333 Kearny street.
- Frink, Geo. K., Merchants' Exchange Bldg., S. F.
- Gardner, Jerome T., 1601 13th Ave. So. S. F., Cal.
- Glover, Cosmos A., from 845 Golden Gate Ave. to 1284 Market, San Francisco.
- Graham, G. F., Shreve Bldg., San Francisco.
- Howard Katherine I.**, from 1542 California to 1418 Larkin street, S. F.
- Jacobs, Louis Cline**, from 2598 Howard street to 830 Market, San Francisco.
- Keenan, A. S.**, from 2790 Harrison to 24th and Harrison street, San Francisco.
- Kenny, William, from St. Luke's Hospital to Alms House, City.
- Miller, Thurlow S., from 1196 McAllister to Chronicle Bldg., City.
- Mitchell, John B., from 1913 Van Ness Ave. to Shreve Bldg., San Francisco.
- Montgomery, W. O., from Lane Hospital to Polk and Vallejo streets.
- Muller, Fred'd C., from 850 1st ave. to 2486 Fulton street, San Francisco.
- Pauson, Chas. A., from Mt. Zion Hospital to 350 Post street, San Francisco.
- Ryan, Louis X., from 776 Hayes street to 617 Fillmore street.
- Ward, Jas. Wm., from 1380 Sutter to 393 Sutter, San Francisco.
- Lindsey, P. S., from 439 3rd street to 1224 3rd street, Santa Monica.
- Yates, Elizabeth M.**, from 442 4th to 501 4th street, Santa Monica.
- O'Brien, Jas. W.**, from 918 6th street to 200½ K street, Sacramento, Cal.
- Gavey, Walter, Kennett, Shasta County, Cal.
- Zobel, Alfred J.**, from 352 Lake street, San Francisco, to 240 Stockton street, S. F.
- Johnson, P. V. K.**, from 1913 Ocean View to Wright & Callender Bldg., Los Angeles.
- Kent, R. W., from Sonora to Columbia, Cal.
- Sawyer, Wilbur A., from San Francisco to 2345 Telegraph ave., Berkeley.
- Haworth, Morris W., from Vacaville to Elks' Bldg., Sacramento, Cal.
- Sanders, Geo. L., 529½ K street, Sacramento, Cal.
- Riehl, Fred'd W. F., from Alameda to 420 Kearny street, San Francisco.
- Buckley, Emma**, from 1915 Van Ness to Phelan Bldg., San Francisco.
- Cutter, Jas. B.**, from Kerckhoff Bldg. to 496 R. F. D., No. 11, Los Angeles.
- Booth, Jas. P.**, from Mason Bldg., to 1220 W 6th street, Los Angeles.
- Alderson, Harry E.**, from Shreve Bldg. to 240 Stockton street, San Francisco.
- Pottenger, F. M.**, from O. T. Johnson Bldg. to Union Trust Bldg. Los Angeles, Cal.
- Browning, Chas. C.**, from O. T. Johnson Bldg. to Union Trust Bldg., Los Angeles.
- Barrett, G. M.**, from 1796 Post to 240 Stockton street, San Francisco.
- Mize, G. H.**, from 2580 Mission street to 350 Post st., San Francisco.
- Robertson, H. M.**, from Riverside to 1317 N. Main street, Santa Ana.
- Glazer, E. F.**, from 2508 Clay street to 391 Sutter street, San Francisco.
- Smith, Jas. Franklin**, from 1700 California street to 86 Post.
- Somers, Geo. B.**, from 2500 Fillmore street to 135 Stockton street.
- Seymour, Jas H.**, from 24th and Castro to 4093 24th street, City.
- Jullien, E. H., from 1059 O'Farrell street to 240 Stockton street.
- Martindale, John H.**, from Auditorium Bldg. to Hotel Leighton, Los Angeles.
- Price, Marshall F., (retired), from address unknown to 1702 Bonnie Brae, Los Angeles.
- Shiels, Jno. Wilson**, from 1380 Sutter to 323 Geary.
- Smith, Arthur M., from Douglas Bldg. to Wright & Callender Bldg., Los Angeles.
- Leadsworth, John R., from Los Angeles to Loma Linda, Cal.
- Atkinson, A. A., from address unknown to Dorris, Siskiyou, County, Cal.
- Russ, Raymond**, from Shreve Bldg. to 240 Stockton street San Francisco.

#### NEW MEMBERS.

- Lucas, Wm., Point Richmond, Cal.
- Montgomery, C. H., Laughlin Bldg., Los Angeles.
- McCue, Jas E., Central Bank Bldg., Oakland.
- Williamson, Mark A., San Rafael, Cal.
- Dwire, Francis B., Los Angeles, Cal.
- Johnson, P. V. K., Los Angeles, Cal.
- Downing, Wm. E., Vallejo, Cal.
- Iland, Minnie, Vallejo, Cal.
- Trask, Henry C., Cloverdale, Cal.
- Cross, Lester E., Stockton, Cal.
- Maddux, J. E., Sebastopol, Cal.
- Folsom, F. N., Forrestville.
- McGovern, J. C., San Luis Obispo, Cal.
- Stover, W. M., San Luis Obispo, Cal.
- Jackson, Paul K., San Luis Obispo.
- Bradberry, R. M., San Luis Obispo.
- Irones, Ruth B., San Diego.
- Smith, F. J., San Diego.
- Pounds, T. C., San Diego.
- Hyde, O. C., Oakland, Cal.
- Sylvester, Florence M., Oakland.
- Sawyer, William A., Berkeley, Cal.
- Channell, W. Leon, Oakland, Cal.
- Briggs, L. H., Oakland, Cal.
- Williams, Annie W., Hayward, Cal.
- Greene, Frances M., Berkeley, Cal.
- Horton, Warren N., Los Angeles.
- Bryson, Chas. W., Los Angeles.
- Carter, W. E., Los Angeles.
- Burkelman, A., Los Angeles, Cal.
- Kenyon, Frank P., Pomona, Cal.
- Pruett, Wm. C., Oakland, Cal.

#### DEATHS.

- Cabral, Jno. S. A., San Francisco, Cal.
- Minor, John Franklin, Alameda.
- Belinge, F. A. A., San Francisco.
- Wallace, A. H.**, Los Angeles, Cal.
- Winn, Albert C.**, Tomales, Cal.
- Macomber, Henry K., Pasadena, Cal.
- Stern, Louis, San Francisco, Cal.
- Marshall, Minora S., San Francisco, Cal.
- Barger, D. E., San Francisco.

#### REINSTATED.

- A. H. Myers, Sugar Pine, Cal.